Situational Psychogenic Anejaculation: A Case Study

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ABSTRACT

Anejaculation is an uncommon clinical entity that may result from a variety of causes, both organic and psychological. Psychogenic anejaculation is influenced by relationship, behavioral, and psychological factors. We present a clinical case of situational anejaculation, which was managed with a combination of techniques that addressed these factors including changes in masturbatory technique, improved marital communication and quality, and reduction of anxiety using cognitive behavioral techniques. It is suggested that the standard techniques of sex therapy be modified and tailored to manage the specific problems of the individual patient.

Key words: Anejaculation, anorgasmia, sex therapy

INTRODUCTION

Anejaculation is defined as complete absence of ejaculation during sexual activity, despite normal erections or nocturnal emissions.\(^1\) It may result from spinal cord injury, retroperitoneal lymph node dissection, diabetes mellitus, transverse myelitis, multiple sclerosis, or psychogenic causes.\(^2\) Although a relatively uncommon occurrence in the general population, over 12,000 new cases of anejaculation are reported annually, of which about 1.5% have a psychogenic origin where there is no demonstrable organic etiology and the problem is considered to be functional.\(^3,4\) Like other sexual disorders, psychogenic anejaculation can be generalized (with all types of sexual behavior and all partners) or situational.\(^5,6\) Men who suffer from situational anejaculation cannot consciously ejaculate during sexual activity but are often able to have normal erections, ejaculate during masturbation or have nocturnal emissions; it can be further characterized as specific for partner or type of sexual activity. Several theories have attempted to explain psychogenic anejaculation including a lack of awareness of one’s body, psychological inhibition due to guilt or fear of loss of control, inadequate sexual arousal (due to autosexual orientation), performance anxiety (being overly focused on pleasing the partner), or negative affect (resentment or hostility) toward the partner; however, these theories have little empirical evidence.\(^2,7-11\) Treatments that have been shown to be effective for psychogenic anejaculation include sex therapy, vibrator stimulation, and electroejaculation.\(^5,7\) We describe a patient with situational psychogenic anejaculation.

CASE REPORT

Mr. A is a 33-year-old married male with heterosexual orientation, a professional from a middle socio-economic urban background. He was referred to the psychiatry department from the reproductive medicine unit, where he and his wife had presented for evaluation of infertility after 18 months of marriage. The couple was initially evaluated for organic causes of anejaculation, which were excluded. They were then referred for psychological intervention.
Mr. A was reported to have anxious and anankastic traits. There was a family history of mental illness in a distant cousin, the details of which were unavailable. He was diagnosed to have obsessive-compulsive disorder at the age of 16 years; the symptoms had remitted with a combination of cognitive and behavioral therapy and medication. At the time of presenting to the hospital, he was on a combination of sertraline (200 mg in the morning), clomipramine (50 mg at bedtime), and bupropion (150 mg at bedtime).

Mr. A had been brought up in a family that followed orthodox Hindu traditions. His first sexual experience was with a friend in a mutual masturbatory exercise during his early teens. This continued for a while till they were discovered and severely rebuked by his parents. He has had no premarital sexual contacts. He watched pornography and masturbated frequently. His knowledge about sex and sexuality was adequate. Following his marriage, Mr. A described his libido as initially normal, but later reduced secondary to his ejaculatory difficulties. The couple had normal foreplay prior to sexual intercourse, and the patient was able to achieve erection sufficient for penetration. Despite thrusting movements for 30-45 minutes, he had never been able to ejaculate or achieve orgasm during penetrative sex with his wife. However, he was able to ejaculate and achieve orgasm within a few minutes of masturbation. The patient’s wife was able to achieve multiple orgasms during sexual activity. The couple had attempted varying sexual positions to try resolving the problem, without success. The sexual problems had resulted in a strained marital relationship with both partners experiencing guilt and reduced confidence.

There was also significant family and societal pressure on the couple to have a child.

Mr. A’s medications were rationalized; clomipramine and bupropion were discontinued, and sertraline was maintained at a dose of 150 mg per day. Therapy sessions with the couple were held weekly for the initial few months, following which they were spaced to fortnightly and later monthly. Each session lasted about 45 minutes to an hour. During the initial sessions, the patient and his wife were seen separately; later, combined sessions were held. The couple was encouraged to discuss their difficulties. Their distress was acknowledged. Causal and treatment beliefs were explored; these were in keeping with the explanatory models prevalent in the local community. Attempts were made to integrate these with the bio-medical model without dismissing or challenging their belief systems. Measures to improve the marital relationship were discussed such as improving communication and enhancing the quality of time spent together. Using the principles of the PLISSIT model of sex therapy, the couple was given permission to discuss their sexual concerns, which were validated as a legitimate health issue. Their expectations of sexual activity and concerns regarding technique were clarified by providing information regarding normal sexual anatomy, physiology, and sexual intercourse. Specific suggestions including focusing on sexual sensations and concentrating on the sexual experience rather than ejaculation were used to help reduce performance anxiety and spectatoring. Since problems persisted despite these interventions, intensive sex therapy was suggested. Progressive sensate focus exercises (initially non-genital and later genital) were initiated. Mr. A described an inability to experience the same degree of stimulation during penetrative sex as compared to that which he experienced during masturbation. Once the ban on masturbation was enforced, he reported an increased desire for sexual activity with his partner. Masturbatory retraining exercises such as switching hands, altering the speed, pressure and technique and using lubricants or condoms were then initiated. Following this, penetrative sex was permitted; steps to reduce spectatoring were discussed once again. Meanwhile, Mr. A and his wife decided to go ahead with Assisted Reproductive Techniques (ART) and underwent two cycles of intrauterine insemination. During a practice session, Mr. A ejaculated for the first time, following which he has been able to ejaculate satisfactorily during a majority of the couple’s sexual interactions.

**DISCUSSION**

The diagnosis of anejaculation of psychogenic etiology is classically based on the variable nature of the ejaculatory dysfunction. Mr. A had anejaculation specific to penetrative sex, but could ejaculate normally during masturbation and had nocturnal emissions. This reasonably rules out the possibility of a medication-induced or organic ejaculatory failure, which tends to be constant, with every partner and in all circumstances and situations.

People with psychogenic anejaculation tend to have behavioral, relationship, and psychological factors that contribute to their dysfunction. These are described below and appear to have been central to anejaculation in Mr. A’s situation.

**Behavioral factors**

Behavioral factors include a preference for and greater arousal and enjoyment from masturbation than from intercourse. Their masturbatory activity often involves an idiosyncratic and vigorous masturbation style, which is carried out with high frequency. This is not easily duplicated during sexual intercourse with their
This was evident in Mr. A’s case, and enforcing a ban on masturbation followed by masturbatory retraining exercises helped alter this pattern. Other factors that contribute to ejaculatory failure include an inability to communicate preferences for stimulation to the partner and a disparity between the reality of sex with the partner [with respect to partner attractiveness or body type, sexual orientation, and specific sex activity performed] and sexual fantasy during masturbation. Mr. A reported both these concerns, which were addressed during sex therapy.

Addressing these issues using a cognitive behavioral model helped resolve the dysfunction. We also postulate that undergoing ART simultaneously with sex therapy helped reduce the pressure on him to perform and diminished anxiety during sexual activity.

### CONCLUSION

Psychogenic anejaculation is a clinical condition that is relatively difficult to treat. While the PLISSIT model was the basic framework used, therapy was modified to manage the idiosyncratic issues and specific problems of the individual patient. A combination of reducing medication, altering masturbatory techniques, resolving relationship issues, reducing anxiety by cognitive behavioral techniques, and the use of insemination to reduce pressure related to intercourse helped the patient overcome his ejaculatory difficulties. Providing basic information regarding sexuality, reducing guilt about sexual functioning, improving the relationship between the couple and a strong relationship between the therapist and patient were significant factors that helped in addressing this complex problem. There is a need for a large series of cases where such therapy is attempted to assess its efficacy, impact, costs, and benefit.

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