International Journal of Advanced Studies in Sexology
© Sexology Institute of Romania
Vol. 5(1), 2023, pp. 42-50

https://www.sexology.ro/jurnal
ISSN 2668-7194 (print), ISSN 2668-9987 (online)
DOI: 10.46388/ijass.2023.1.6

CBT TECHNIQUES FOR MALE DELAYED EJACULATION. A CASE STUDY

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Abstract

Delayed ejaculation (DE) is a rare and poorly defined form of male sexual dysfunction. It is probably the least researched sexual disorder due to its low prevalence rates, affecting 1-4% of men. Individuals with this condition suffer from difficulty or inability to reach ejaculation latency and diminished control. Consequently, patients and their partners experience lower sexual satisfaction, affecting their overall relationship satisfaction negatively. The current case study is aimed at providing a comprehensive overview of the current knowledge on the definition and explanations of male delayed ejaculation. Additionally, to investigate the efficacy of CBT techniques on men with (DE). Findings indicate that ejaculation control is negatively correlated with sexual performance and positively correlated with relationship intimacy. Following CBT sessions on a weekly basis, reduction of performance anxiety in subject 1 contributed in ejaculation control enhancement of (170%) and (200%) at post-intervention and follow-up. Whereas, promoting relationship intimacy in subject 2 lead to a growth of (146%) and (230%) at similar evaluation assessment. The relevance of this outcome is providing a significant relevance to CBT techniques in treating (DE) and avoiding the development of other psychological or sexual disorders. For future research, we suggest including a larger sample size in order to improve the study's statistical power, strengthen scores' accuracy and reduce the likelihood of possible errors.

Key words: Delayed ejaculation, sexual dysfunction, performance anxiety, relationship intimacy, CBT.

INTRODUCTION

Delayed ejaculation receives the least attention among male sexual dysfunctions due to its diminished prevalence and the poor familiarity with this disorder (Abdel-Hamid et al., 2016). Accordingly, limited investigation has been carried out concerning the causes, assessment and management of this disorder (Perelman et al., 2016). In spite of that, its consequences are numerous and severe; affecting the patient's well-being, self-esteem, body-image and the overall sexual satisfaction in sexual acts, leading to decreased fulfillment in the relationship for both the patients and their partners (Rowland et al., 2023).

Men with delayed ejaculation might develop other mental health issues. Such as: psychological distress, depression and anxiety disorders. In addition, other sexual dysfunctions may give rise, as erectile dysfunction (Di Sante et al., 2016).

In the current literature, research show modest significance to psychological and pharmacological treatment to male delayed ejaculation. Nonetheless, CBT techniques tend to show

greatest success rate in increasing ejaculation control. Various strategies can be approached including; sexual performance reduction, relationship intimacy promotion and relaxing strategies adaptation (Chen et al., 2016).

Our research work contributed to investigate the impact of sexual performance anxiety and relationship intimacy among men with delayed ejaculation. In addition, the level of contribution to each factor was assessed. Our case study explored in-depth each subject, allowing us to gather a great quantity of data, covering different aspects of their lives through semi-structured interviews and through questionnaires completion.

The importance of our paperwork relied in exploring the influence of two specific CBT strategies on delayed ejaculation. We studied the relationship of sexual performance anxiety reduction and relationship intimacy promotion with delayed ejaculation. Furthermore, the effectiveness rate of both techniques was conducted and compared.

Background / Presentation of relevant literature

Delayed ejaculation

Male delayed ejaculation, also called; inhibited ejaculation, inadequate ejaculation or retarded ejaculation.

The term is used to describe the inability or the significant difficulty to ejaculate at will, wherefore it requires an extended period of sexual stimulation to reach orgasm and ejaculate (Abdel-Hamid et al., 2017). DE is defined in DSM-5 as a persistent delay or absence of ejaculation, despite the presence of adequate desire, arousal, and stimulation on 75% to 100% of partnered sexual acts for a period of 6 months the least, leading to individual's consequential distress (APA, 2013).

Despite the marked distress and interpersonal difficulties DE causes, it is considered poorly studied and least acknowledged of male sexual dysfunctions (Chen et al., 2016). An estimated prevalence of 1-4% of male population experience delayed ejaculation. However, according to USA National Health and Social Life Survey (NHSLS), 7.78% of men with an age range between 18 and 59 desired to ejaculate sooner (Rowland et al., 2023).

Males diagnosed with DE tend to suffer more from mental health issues, lower sexual satisfaction and increased anxiety about their sexual performance (Hamid et al., 2011). They are more likely to fake an orgasm in order to avoid possible negative reactions from their partners (Hall et al., 2020). Some partners of men with DE might find pleasure in the longer duration of sexual intercourse. However, progressively, they might experience anger, discomfort, guilt or self-doubt in relation to their attractiveness and question their desirability (Hall et al., 2020).

DE can be lifelong (the issue arises as soon as a person reaches sexual maturity) or acquired (happens following a period of functioning sexual acts). Additionally, it could be generalized (unlimited to specific sexual scenarios or stimulation) or situational (occurs only under certain circumstances) (Abdel-Hamid et al., 2016).

Explanations to DE are multifactorial and consist of biological, psychosexual, and cultural factors. Biological causes include certain medication and substances such as: antidepressants, antipsychotics, excessive use of alcohol or drugs. Among psychological factors, these refer to poor body image, inadequate sexual education, general anxiety, unexpressed anger, childhood sexual abuse, pregnancy fears and religious taboos (Di Sante et al., 2016).

At last, sexual performance anxiety is found to contribute significantly to DE among men with low self-confidence, as they experience high pressure to feel and appear attractive, perform adequately and to satisfy their partner (Perelman et al., 2020).

Managing DE is challenging as it requires a higher attention to the causes and subtypes of the condition. Therefore, some patients do not benefit from a strict treatment regimen (Abdel-Hamid et al., 2017).

There are numerous methods to approach DE, including psychosexual interventions and pharmacotherapy (Perelman et al., 2016). On the basis of pharmacological and physiological considerations, attempts have been made to

treat DE with off-label medications. Yet there isn't a medicine that has been approved (Hall et al., 2020). These drugs have a limited effectiveness rate, decreased success and can have serious side effects (Perelman et al., 2020). At present, there is no secure, reliable and effective drug for DE. However, some medications are prescribed despite the low evidence of support. For example: testosterone, oxytocin, buspirone, amantadine, cyproheptadine (Abdel-Hamid et al., 2016). Psychosexual therapeutic interventions including cognitive behavioral therapy, individual or couple sex-therapy and sex education. These focus particularly upon teaching the client techniques to; decrease performance anxiety, alter focus from oneself to one's partner, increase couple communication skills related to sex and sexual fantasies, build trust and intimacy in the relationship, enhance sensory tolerance, meditate and be mindful, relax one's muscles and breath efficiently (Abdel-Hamid et al., 2017).

Finally, The Sexual Tipping Point (STP) is a biopsychosocial model which acknowledges the complex interaction of biological, psychological, relational and sociocultural factors that establish a sexual reaction (Perelman et al., 2020). STP demonstrates a spectrum of mental and physical components which consist of the exciting and inhibiting factors that affect ejaculatory response in men (Perelman et al., 2016). Mental factors consist of thoughts, emotions, relations, culture and more. Physical factors include genetics, anatomy, neurology, substance effect and more (Perelman et al., 2016). This model aims to minimize inhibiting thoughts and maximize excitation and arousal. It helps the patient to identify behaviors that enhance his ability to experience higher levels of psychosexual arousal within mutually satisfying experiences, as well as in showing improvement of ejaculatory function and control (Perelman et al., 2020). STP success rates are greatly high as it surpasses 75% of effectiveness. One out of five men tend to show a valuable enhancement after adopting these strategies in fewer than 6 weeks (Perelman et al., 2016)

Performance anxiety

The worry that accompanies engaging in sexual activity is known as performance anxiety. Almost all forms of sexual dysfunction in both men and women share this common maintaining factor (Grabski et al., 2022). Masters and Johnson emphasized that performance anxiety affects sexual functioning in individuals and in couples essentially (Barlow et al., 1986).

Due to its ability to divert attention from sensual feelings, decrease sexual confidence, and encourage sexual avoidance, performance anxiety was regarded by many theorists as the primary causal factor influencing sexual arousal. It is a significant inhibitor of autonomic nervous system functioning and of psychogenic sexual dysfunction, particularly in men (Grabski et al., 2022).

Sexual performance anxiety affects 9-25% of men and 6-16% of women, making it the leading cause to the majority of sexual dysfunctions (Pyke et al., 2020). Some research show a higher rates of SPA among gay men due to minority stress and the excessive exposure to stigmatization and discrimination (Grabski et al., 2022). Other findings indicate that society's consideration of homosexuality as abnormal is a major factor to strengthen SPA among gay men (Mayo et al., 1996).

SPA usually arises from negative body image and boy dissatisfaction (Carvalheira et al., 2016) internalized homophobia (Grabski et al., 2023), penis appearance concerns (Wyatt et al., 2020), excessive need to please partners (Barlow et al., 1986), poor economic circumstances (Grabski et al., 2022), fear of inadequacy, spectatoring role (self-directed attentional focus during sex), cognitive distractions that shift one's attention from relevant sexual activities (McCabe et al., 2010). On the contrary, commitment in relationships, higher education degree, sexual education, therapy and increased number of sexual experiences all lower the likelihood of SPA (Grabski et al., 2022).

Despite the modest evidence to their effectiveness, cognitive behavioral therapy, mindfulness meditation and serotonergic anxiolyt-

ics show considerable efficacy to cope with sexual performance anxiety (Pyke et al., 2020).

METHODOLOGY

General objective, specific objective, hypotheses and research design

The general objective:

Studying the effect of CBT techniques among men with delayed ejaculation.

The specific objective:

Investigating the role of relationship intimacy on male delayed ejaculation.

Investigating the role of sexual performance anxiety on male delayed ejaculation.

Hypotheses:

1. Sexual performance anxiety is negatively correlated with ejaculation control
2. Relationship intimacy is positively correlated with ejaculation control
3. Ejaculation control at follow-up outweighs the one at post-intervention

Research design: a case study

The variables:

- Independent variables: relationship intimacy, sexual performance anxiety
- Dependent variable: delayed ejaculation

Participants

David is a homosexual man. He is 25 years old with a Romanian nationality, living in Cluj-Napoca city. He has graduated the Faculty of Letters within the specialization of modern applied languages at Babes Bolyai University of Cluj-Napoca. Until September 2022 he worked at a traveling agency call center as a customer service agent. During the same month, a significant transformation in career has out folded as he joined a demanding training in an aviation company for the position of a flight attendant. The training took place in Gdansk, Poland for a period of 6 weeks. Meanwhile, his romantic relationship turned into a long distance one due to job circumstances. The subject identifies as a shy, attractive and outstanding person. He has an anxious attachment style and he is diagnosed with generalized anxiety disorder. Romantically, he is in a stable relationship for about 2 years. Moreover, he is sexually active since the age of 17. However, he has struggled with delayed ejaculation since the beginning of his sexual life.

Alex is a 30 years old heterosexual man with a Romanian citizenship, living in the city of Cluj-Napoca. He is in a new relationship with a period of 1 month approximately. He has graduated from FSEGA University within the specialization of general economics. However, he is working as a bartender in a restaurant in Cluj-Napoca. The subject identifies as a sociable, extravert and intelligent person. Sexually, he claims to experience less satisfaction in sexual acts due to serious difficulty to reach ejaculation. Trust, commitment and intimacy are key factors in strengthening satisfaction in relationship and in sex from his perspective.

Instruments

Brief Sexual Performance Anxiety Scale (BSPA):

The BSPA is an 8-item instrument developed in order to assess the sexual performance anxiety. The scale consists of 8 statements on a 5 point Likert format, with each item ranging from 0 (No anxiety) to 4 (Extreme Anxiety). Subjects are asked to rate their level of anxiety in specific sexual situation presented in the 8 statements. For instance: "When my partner feels my sexual performance is inadequate", "When my partner does not ejaculate/orgasm" The higher the score is the higher the performance anxiety in sexual acts. The total score ranges from a minimum result of 0 and a maximum outcome of 32. The BSPAS inventory is an inclusive instrument as it applies to all subjects regardless their age, culture, sexual orientation or gender identity. Studies show a significant internal consistency, $\alpha = .88$.

Personal Assessment of Intimacy in Relationships (PAIR)

The PAIR scale was found and constructed by Schaefer and Olson in the year of 1981.

It aims to examine the levels of intimacy in relationships among married or unmarried couples. The 36 items inventory measures relationship intimacy in five main domains; emotionally, sexually, socially, intellectually and recreationally. Respondents answer each item on a 5-point scale ranging from 1 (Does not describe my relationship at all) to 5 (Describes my relationship very well). The final score ranges from a minimum score of 36 and a maximum score of 180. The higher the ultimate result is, the more intimate the relationship is. PAIR inventory could be useful as well for individual respondents and how they perceive their ideal relationship.

Male Sexual Health Questionnaire (MSHQ):

The MSHQ is a self-administered assessment found and developed by Raymond C Rosen in 2004 in the USA. In the beginning the instrument had 75 items which were re-evaluated and reviewed to come up with final version consisting of 25 items. It provides a detailed evaluation of men sexual functioning through the three scales: erection scale (3 items, score range 0-15), ejaculation scale (7 items, score range 1-35), satisfaction scale (6 items, score range 6-30) and other additional 9 items examining sexual activity and sexual desire. A Likert type format is included in the response option, ranging from 1 to 5 or 6 points, along with dichotomous (Yes/No) scales. The MSHQ instrument has a high reliability with a Cronbach's Alpha of 0.93 for erection scale, 0.84 for ejaculation scale and 0.90 for satisfaction scale. Similarly, test-retest reliability is significantly high for all three scales; 0.94 for erection scale, 0.85 for ejaculation scale and 0.88 for satisfaction scale.

Procedure

Each subject was interviewed separately, face to face and through a semi structured interview. Afterwards, the instruments were provided to subjects to complete online through Google forms questionnaire. Clear instructions were provided for completion and desirability was controlled by explaining that their identity is anonymous. Each participant was asked for their permission and agreement for participating in the study.

Where appropriate, certain items will be explained and exemplified (we will provide our e-mail address and contact telephone number), in order to ensure the most accurate assessment of the concepts. We appreciate that the completion of the questionnaire will have an average duration of 15-20 minutes, depending on the availability of participants. The data collection period was between April 29th, 2021 until November 8th, 2022.

The order of administering the instruments was as follows; Brief Sexual Performance Anxiety Scale (BSPA) followed by Male Sexual Health Questionnaire (MSHQ) to subject 1. Personal Assessment of Intimacy in Relationships (PAIR) followed by Male Sexual Health Questionnaire (MSHQ) to subject 2. Subjects will be informed that at the end of the study they will be able to dispose of the results obtained.

Completing the questionnaires will be repeated on three timings; pre-intervention, post intervention (after one month) and at the follow-up (after 6 months). The intervention is represented through CBT sessions with a professional, authorized and experienced psychotherapist from Cluj-Napoca. The psychotherapist will apply different techniques with each patient; reducing sexual performance anxiety with subject 1 and boosting relationship intimacy with subject 2. Sessions will be held physically with duration of 50 minutes per session on a weekly basis.

RESULTS

In the first case, BSPA outcome demonstrated a statistically significant decline in the overall score, starting at 29 at the pre-intervention, 20 at the post-intervention, and 12 at the follow-up. In return, the results of MSHQ assessment were as follows: erection scale results were constant with a maximum score of 15, satisfaction scale and ejaculation scale showed an important improvement within the three timings, represented as: (15,26,31) and

(10,20,27) simultaneously. The overall data indicates the efficacy of the CBT technique in reducing sexual performance anxiety, contributing to higher sexual functioning especially in ejaculation control. The decline in sexual performance anxiety provided a boost in ejaculation control, which confirms our first hypothesis.

In the second case, PAIR was applied to assess the relationship intimacy among five aspects. The results of each scale are represented in table number 3 indicating a clear boost of relationship intimacy among all five dimensions. The CBT technique of promoting relationship intimacy indicated an increased efficacy. An average of total scores from each scale was calculated and illustrated in the following manner: (19.8) at the pre-intervention, (22.6) at post-intervention and (24) at the follow-up.

Furthermore, sexual functioning observed a significant improvement among all three scales. For instance: total score of ejaculation control stood at 13 in the pre-intervention, enhancing to score of 19 at the post-intervention and reaching an exceptional score of 30 at the follow-up. Findings indicate a great success rate of CBT technique in boosting relationship intimacy with time. Additionally, greater relationship intimacy proved a positive correlation with ejaculation control, giving relevance to our second hypothesis.

Ejaculation control for both subjects was significantly higher than the score obtained at the post- intervention. There was a five-point increase in the first subject's total ejaculation scale score, and an eleven-point improvement was seen in the second subject. As a result, our third hypothesis is statistically supported.

Subject 1: David

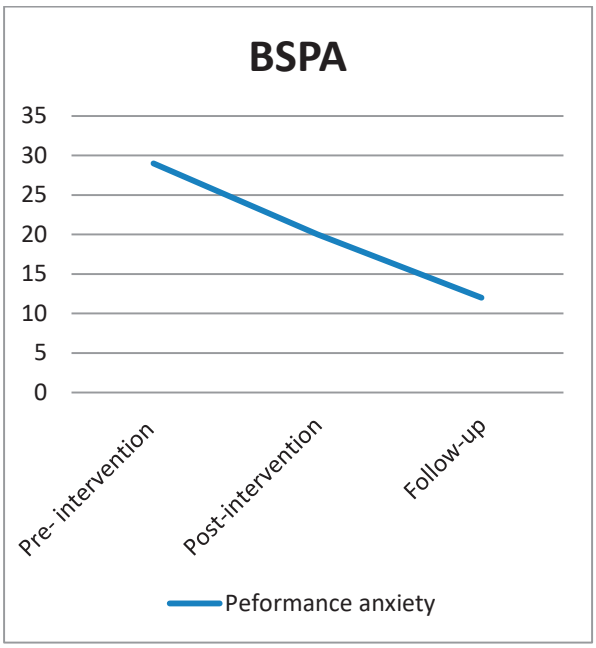

Fig 1; performance anxiety instrument in subject 1

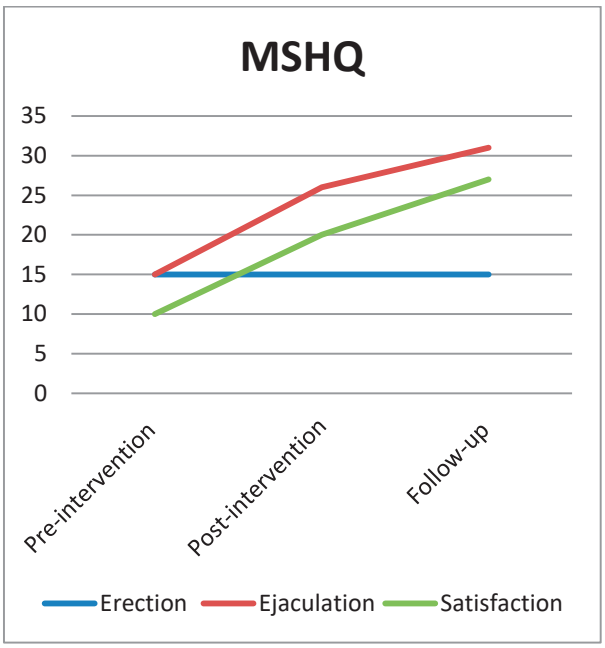

Fig 2; male sexual health instrument in subject 1

Subject 2: Alex

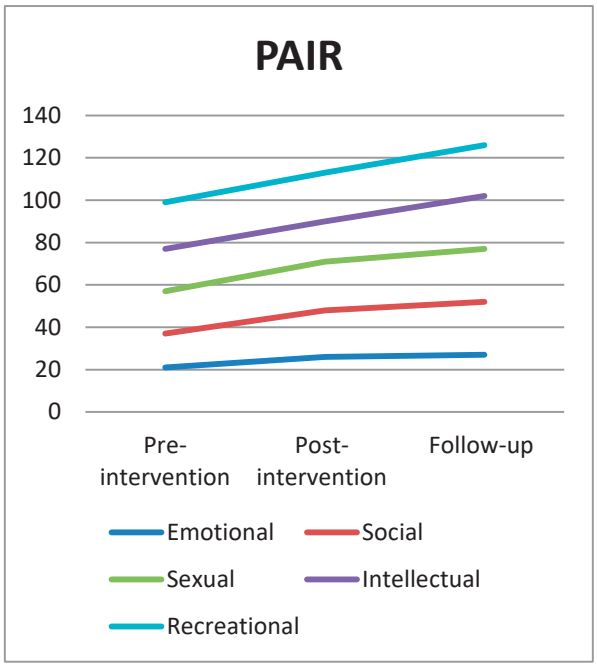

Fig 3; relationship intimacy instrument in subject 2

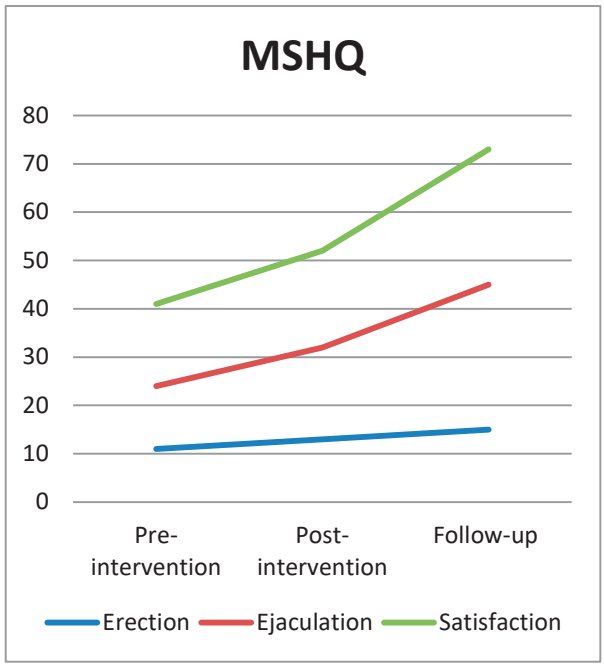

Fig 4; male sexual health instrument in subject 2

DISCUSSION

In our paperwork, we intended to investigate the efficacy of specific CBT techniques on men with delayed ejaculation. We believed the lower the sexual performance anxiety is, the higher the ejaculation control is. In plus, we predicted an increased ejaculation control when relationship intimacy is promoted. Lastly, we expected a higher ejaculation control at the follow-up timing in comparison with the one at the post-intervention. The analysis of our findings showed a significant statistical support to all three hypotheses.

Firstly, directing one's attention from excessive focus on body-image and sexual performance to the excitements in the sexual act increases the sexual satisfaction for both the patient and their partner. In addition, rigid thoughts as: "I must ejaculate now, otherwise I am a loser", "I will fail again", "I am incapable of having sex" inhibit one's ability to experience greater satisfaction. Addressing these thoughts is essential, transforming them into more flexible ones leads to a comfortable and sensual atmosphere. In plus, the intensity of negative emotions (such as: guilt, disappointment, fear and anxiety) will be diminished, allowing other functional emotions to take place (such as: pleasure, happiness and enjoyment). Therefore, the patient will act more natural, be more present and less critical, which contributes to higher sexual satisfaction, more intense orgasm and greater ejaculation control.

Secondly, promoting closeness, connection and commitment in a relationship in five dimensions of intimacy: emotionally, socially, sexually, intellectually and recreationally, contribute in a better romantic and sexual life. Comfort and trust increase the interest, enjoyment and openness for various and unusual sexual activities, activating one's sexual excitement, reaching orgasm and ejaculation more intensively and more rapidly.

Thirdly, the efficacy of cognitive behavioral therapy is observed greater across the time. As stabled, each subject attended one CBT session each week, obtaining 4 sessions until the post-intervention and a total of 24 sessions until the follow-up. Therefore, improvement shall be observed in a more extraordinary manner at the follow-up. In other words, applying the required CBT techniques repetitively will in-

crease their efficacy, which grows one's capacity of ejaculation control.

Our research yielded similar results to earlier studies, indicating the effectiveness of cognitive behavioral therapy in controlling ejaculation latency. In terms of promoting intimacy in relationships and lowering anxiety associated with sexual performance, Perelman's psychosexual intervention has a success rate comparable to ours, based on the Sexual Tipping Point model. Nevertheless, we aimed to be specific and detailed about the CBT techniques we used in the study. The significance of discussing different approaches to managing DE brings attention to multiple and complicated factors leading to the development of DE. In other words, giving relevance to various methods in CBT, examining their effectiveness, and achieving a high success rate for both strategies illustrate the multifactorial causes contributing to DE.

When compared to previous studies, our primary emphasis was on testing psychological interventions rather than medical treatments. For instance, Chen et al. overvalued the efficacy of medications by studying the effects of multiple drugs on delayed ejaculation. However, psychosexual strategies were underestimated, receiving minimum attention.

The importance of our investigation relied in presenting a rare male sexual dysfunction that is underappreciated in the current literature. Exploring to the depth several cases with different causes, results in identifying multiple variables leading to the development of DE. Additionally, testing the efficacy of various CBT techniques demonstrated the increased success rate of psychological interventions with different methods to manage DE.

CONCLUSION

In this article, we have discussed male delayed ejaculation and the various complex factors that contribute in developing this disorder. We assessed the multifactorial explanations consisting of biological, psychological, sexual and cultural aspects. Furthermore, we aimed to study the role relationship intimacy and sexual performance anxiety, have on men with delayed ejaculation dysfunction. The findings of our research provide a statistical support to our three hypotheses. The results indicated a significant positive correlation with relationship intimacy and ejaculation control, a significant negative correlation with sexual performance anxiety and ejaculation control and a higher efficacy of ejaculation control at the follow-up in comparison with the ability at post-intervention.

Limitation

Firstly, our study is a self- report questionnaire that might have multiple disadvantages. Participants are able to provide more socially acceptable responses rather than correct ones. Subjects tend to desire to look good and to afford answers that are socially desirable. reliability and it might contribute to errors and biases.

Secondly, confounding variables are considered an outside influence that changes the effect of the dependent and the independent variables. Some outside variables might be difficult to predict and to control and that may undesirably have an effect. For example: the individuals' tiredness, lifestyle, eating habits, body mass index, home, environment, parents' personalities, substance misuse, alcohol and smoking status, unmentioned illnesses and more.

Future studies

First of all, we suggest including a wider sample size which will increase the statistical power of the study and will reduce multiple possible errors and the scores' inaccuracy.

Second of all, we propose a scientifically and an authorized translation and adaptation of all used instruments, items and responses in the study to Romanian language which will enhance participants' understanding of the questionnaire and will increase the correctness of the scores.

Third of all, we recommend interviews and face-to-face study, where it is possible, to avoid biases and socially desirable responses provided through online self-reported surveys.

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