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PLEASURLESS EJACULATION

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Abstract

Chronic lack of pleasure at the time of ejaculation is a rare sexual complaint. During a period of three years we have seen only six cases. Patients having a psychological etiology can be treated while the role of organic factors is questionable.

Introduction

Chronic lack of pleasure at the time of ejaculation is a rare complaint. In ejaculatory anhedonia (Dormoont, 1975), ejaculation is normal and forceful while in partial ejaculatory incompetence (Kaplan, 1974), there is seepage of semen without pleasurable sensation. Ejaculatory anhedonia is stated to be a condition of psychological etiology. Partial ejaculatory incompetence may be organic or psychogenic in origin.

The present study deals with our experience with the etiology and therapy of cases of pleasureless ejaculation diagnosed during a period of three years.

Material and Methods

This report is based on the records of men complaining of pleasurless ejaculation examined at the sexology clinic of Benha Faculty of Medicine, during the years 1982-1984. Cases having apparently normal erection and duration of the sexual act, with chronic lack of pleasure, were considered. Those patients compaining of transient experiences of pleasureless ejaculation and those having the symptom associated with premature ejaculation or impotence were excluded. A complete sexual history and examination was achieved in every patient using a previously described scheme (El-Bayoumi et al., 1984). Six

cases constituted the material of the study.

Therapeutically, a case of ejaculatory anhedonia was managed by psychoanolytically oriented psychotherapy (Katz, 1975). Patients having partial ejaculatory impotence of a psychogenic etiology were treated with the behavioral technique of desensitization with non-demanding stimulation (Kaplan, 1974). Those with organic factors (chronic prostatitis, diabetes) were treated accordingly.

Results

In the present study one patient was diagnosed as having ejaculatory anhedonia and 5 patients had partial ejaculatory incompetence. The etiologic and clinical findings and therapeutic results are presented in table I. The patient with anhedonia had had marked sexual prohibitons during childhood and adolescence. Although he was practicing masturbation regulorly and had also occassional sexual acts with women, he continued to have lack of pleasure during ejaculation starting at age of 18 years.

Two of the patients having seminal seepage were diagnosed as having a wife factor contributing to their complaint. One patient reported boredom and loss of enabling image and the other patient had marital problems with his infertile partner. Treatment of chronic prostatitis in one of our patients did not improve the patient's symptom. Further inquiry revealed marital disharmony and he refused to bring the wife for marital and sex therapy sessions. The patient with juvenile diabetes reported normal mechanics of the sexual function. Diabetes was controlled and the bulbocavernous and anal reflexes could be elicited. Therapeutic trial with sensote-focus exercises utilizing masturbation failed.

An elderly male complaining of seminal seepage was given injections of depot-testosterone, 250 mg every two weeks. Restoration of the sensation of pleasurable ejaculation was achieved after two months of treatment.

Table I: Etiologic, clinical and theraputic findings in six patients complaining of pleasureless ejaculation.

Patient No.	Age (Yrs)	Marital Status	Symptom	Duration (Yrs)	Etiology	Result of Therapy
1	25	Single	Anhedonia	7	Inhibitions	Ineffective
2	33	Married	PEI*	2	Wife factor	Effective
3	37	Married	PEI*	1.5	Wife factor	Effective
4	45	Married	PEI*	3	Chronic prostatitis	Ineffective
5	27	Single	PEI*	1	Juvenile diabetes	Ineffective
6	59	Married	PEI*	2	Hormonal?	Effective

* PEI : Partial ejaculatory incompetence.

Discussion

Orgasm is the pleasurable sensation that accompanies ejaculation. It is a cortical sensory experience which is different from ejaculation. Male climax includes a psychological component of pleasure (orgasm) and a physiological component of ejaculation (emission phase and ejaculatory phase). Dissociation of the two components may occur. Ejaculation without orgasm occurs in certain spinal tumours, some cases of petit-mal, heroin and morphine withdrawal syndromes, electroejaculation (Oliven, 1974), and in ejaculatory anhedonia and partial ejaculatory incompetence. Orgasm without ejaculation occurs in retrograde ejaculation, aspermia, and non-emission (El-Bayoumi et al., 1983).

Stimuli for orgasmic sensation arise mainly from contractions of the striated bulbar and perineal muscles during the ejaculatory phase. These stimuli can also arise from contractions of the smooth muscles of organs of the emission phase (prostate, seminal vesicles, vas deferens) and from skin of the genitals (Cole,1979). Moreover, some spinal cord injured men report orgasm in spite of complete denervation of all pelvic structures. These orgasms derive largely from cognitional eroticism and may be entirely independent of genitopelvic sensation and action (Money, 1960).

Ejaculatory anhedonia (orgastic impotence, male anorgasmy) is scarcely reported in the literature (Dormont, 1975-Katz, 1975-O'Connor and

O'Connor,1980). This complaint of psychogenic etiology may be a component of a generalized anhedonia, a part of a diffuse isolation of feeling in which sex is usually carried out mechanically in individuals of markedly obsessional character structure, or a type of hysterical anesthesia which allows the patient to withdraw his attention from the intense sexual stimulation at the moment of orgasm due to denial of sexual excitement, based on its unacceptability to the patient's superego (Katz, 1975). Our patient with ejaculatory anhedonia had experienced marked sexual prohibitions during childhood and adolescence which could be responsible for unconscious deprivation of pleasure as a means of avoiding what had been conceived as parental punishment. Treatment for several months did not change the patient's complaint. This has been also the experience of other authors (Dormont, 1975-O'Connor and O'Connor, 1980).

Our experience with the symptom of partial ejaculatory incompetence is apparently limited. During a three-years period we have been consulted by only 5 patients. Although a psychogenic etiology was apparent in 2 patients who responded to sex therapy, an organic etiology is questionable in 2 other cases. Treatment of chronic prostatitis in one patient did not restore the sensation of pleasurable ejaculation and the other patient, having diabetes, was neurologically free. We feel that the symptom of partial ejaculatory incompetence deserves more studies at different sex centers to clarify its etiology.

The elderly male complaining of pleasureless seminal seepage deserves special comment. Initially we thought that the patient had misinterpreted the physiological changes of aging, including decreased force of ejaculation with consequent decrease of the sensation of pleasure. However, due to total lack of pleasure we administered testosterone iniections resulted in restoration of pleasurable ejaculation. This response may be a placebo effect or otherwise the patient had a relative testosterone deficiency. Relative testosterone deficiency can cause aspermia despite normal erection and sexual act (Kjessler and Lundberg, 1974), and in our patient it may be the cause of his pleasureless ejaculation.

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