

CASE REPORT

A Case Report on the Permission, Limited Information, Specific Suggestions and Intensive Therapy (PLISSIT) model: Approach and Guide for Patients with Premature Ejaculation and Anxiety Disorder

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ABSTRACT

Premature ejaculation (PE) is a common sexual disorder in men, characterized by inability to delay ejaculation sufficiently for satisfactory sexual intercourse. PE can cause psychological distress and negatively affect the quality of life of the sufferers and their partners, and may lead to marital discord. We reported a case of a 36-year-old man suffering from PE and an anxiety disorder, and the therapeutic challenges with a selective serotonin reuptake inhibitor (SSRI). The utilization of PLISSIT model for the intervention of PE for this patient and his partner was described.

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INTRODUCTION

Premature ejaculation (PE) is a sexual dysfunction that occurs when a man consistently ejaculates earlier than he or his partner would like during sexual intercourse (SI). PE had previously been defined as the inability to exert voluntary control over the ejaculatory reflex (1). Approximately one-fifth of men are affected by PE, up to three-fifths in some studies, and it is considered to be the most common male sexual disorder (1,2).

The World Health Organization (WHO) describes PE as "the inability to delay ejaculation sufficient to enjoy lovemaking, which is manifested by either an occurrence of ejaculation before or very soon after the beginning of intercourse or ejaculation occurring in the absence of sufficient erection to make intercourse possible (1)." Research suggested that any ejaculation that occurs less

than 1 minute after vaginal penetration is "premature" while others suggest that this intravaginal ejaculation latency time (IELT) should generally be at least four minutes, with anything less than this is considered pathological (1).

We reported a case of a 36-year-old man with PE with co-morbid panic disorder without agoraphobia and described how a step-by-step approach using the PLISSIT model can benefit both the patient and his partner.

CASE REPORT

A 36-year-old married Malay architect from Kuala Lumpur, Malaysia presented with a history suggestive of PE for the past one year. The patient and his wife first sought treatment due to inability to conceive. There were no issues identified in his wife's fertility assessment. The patient was subsequently referred for further assessment which revealed that he was ejaculating too fast when they had SI, from the beginning of their marriage. This situation led to disappointment and marital discord. The patient reported that before marriage, he practised

masturbation at least twice a week and ejaculated normally. This went on despite his belief that masturbation was against his religious beliefs and he was sinful because of his acts. When he was in his early adolescence, he read an article stating frequent self-masturbation would cause sexual inadequacy later in life. He became worried and anxious as he imagined damaged genitalia due to masturbatory behaviour. He then resolved to stop masturbating but he was not able to.

After he was married, he became nervous about his sexual performance despite being able to be aroused by his wife and enjoy foreplay which led to erection. However, upon the first penetration, he ejaculated sooner than he intended to, especially when his wife was in lingerie, leading to anorgasmia. They subsequently did not have SI and he frequently felt anxious and thought he was going to fail at another attempt of SI. He had anxiety symptoms that fit the diagnosis of panic disorder without agoraphobia following an assessment by a psychiatrist. He was prescribed tablet citalopram 5 mg daily. He reported feeling better after treatment as he became less anxious. However, his PE only improved by around 25%.

To overcome his sexual inadequacy, he tried different sexual techniques like cunnilingus based on pornography movies. However, his wife was "turned off" by his PE and disliked the idea of watching pornography together to "spice up" their relationship as she felt uncomfortable with the contents of the movies. The patient reported that he had erection and could penetrate his wife but the duration was too short for his wife to achieve orgasm. At times, when they had SI, they would stop halfway since both became tired and there was only a partial erection. This caused their sexual frequency to dwindle.

He consulted the doctor and the citalopram dosage was increased from 5 mg to 10 mg and subsequently 20 mg daily. While his anxiety attacks and premature ejaculation improved with medication dose adjustment, he experienced less sexual desire towards his wife. To address the problem of low sexual desire, the citalopram dosage was reduced back to 5 mg daily, with agomelatine 25 mg nocte added. The patient and his wife also had intervention for PE based on the PLISSIT model framework as described in the Discussion section.

DISCUSSION

PE can affect a patient's psychological wellbeing, quality of life, relationship and intimacy (3). We described the case of a patient with PE with co-morbid panic disorder where a comprehensive treatment using the PLISSIT model was administered. PLISSIT, described by Jack Annon (4) refers to a modeling system employed in the field of sexology to determine and accomplish specific objectives at the different levels of intervention for

individuals with sexual difficulties. The PLISSIT model is a counselling model used in sex therapy to assess and manage the patient's sexual concerns. PLISSIT model is primarily psychological in its approach, though it incorporates elements of behavioural intervention. PLISSIT is an acronym for the four levels of intervention, which are permission (P), limited information (LI), specific suggestions (SS) and intensive therapy (IT). The four levels of increasing intervention and interaction are related to the type and amount of help given to a patient. The varying levels mainly revolve around what the patient is seeking help for and how comfortable they are in discussing sensuality, sexual function and sexual health issues in the context of their sexual difficulties.

For the permission level, the clinician gives the patient permission to feel comfortable about and to discuss matters that would otherwise be too embarrassing for the individual to discuss. In the first stage of therapy for this patient and his wife, permission to discuss the sexual issues was sought at the beginning of the consultation.

The limited information level involves providing information and psychosexual education based on the sexual problems. In this case, we explained the sexual response cycle and the concept of how human beings respond to feelings of sexual desire, arousal, and sexual satisfaction to the patient and his wife. As sexual stimulation is important to enhance the chances of the partner of a man with PE reaching orgasm after penetration, sexual stimulation like cunnilingus and sustained foreplay can be performed. The couple's sexual myths were addressed accordingly, e.g., the infertility and premature ejaculation may not be very closely linked because if the patient can ejaculate inside his wife's vagina, in theory, she can be impregnated. Other sexual myths that were clarified in this case include sexual positions which are likely to delay ejaculation. The patient and his wife were also given psychoeducation on panic disorder, as anxiety is commonly seen in PE (5). The patient and his wife indicated understanding of the information discussed, including sexual health and anatomy.

The specific suggestions level involves making specific suggestions based on a full evaluation of the patient's problems. In this case, the couple was advised on the stop-and-start technique and squeeze technique. These are the behavioural techniques that can help with premature ejaculation. However, they gave feedback that the wife disliked the squeeze technique as it was a "messy business" as she was not able to grip the frenulum of the penis, which was soaked with vaginal lubrication. The stop-and-start technique caused his erection to be less firm, leading to anti-climax.

For the fourth and final level, which is intensive therapy, the patient may be referred to a specially trained expert, for example, a sex therapist, for further management.

This level may also involve psychological therapy and a pharmacological approach. In this case, the patient was referred to an expert medical professional with training in sexology for expert opinion. An SSRI at low dose could offer therapeutic benefits for both anxiety disorder and premature ejaculation. Further consultation on his medication dose adjustment was pivotal for his adherence. Reduction in the dose of citalopram and augmentation with agomelatine provided different pharmacological pathways to address the sexual side effects of the SSRI and treat his anxiety disorder.

CONCLUSION

In this case report, we described the management of a 36-year-old married man with PE and panic disorder on SSRI therapy. Behavioural intervention for PE based on the PLISSIT model was described. The case demonstrated the utilization of pharmacological and behavioural approaches for the treatment of a patient with PE with a co-morbid anxiety disorder. Adjustment of his medication regimen with the addition of agomelatine to SSRI provided different pharmacological pathways to address the sexual side effects of SSRI and treat his anxiety disorder. This case report demonstrated the practicality of the PLISSIT model for intervention of sexual problems that regular mental health professionals and other multidisciplinary team members can employ.

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