Diagnosing and Treatment Options for Premature Ejaculation

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Abstract

“Premature Ejaculation is a sexual problem that may have a significant, negative effect upon an individual’s or a couple’s well-being.” (Premature Ejaculation, 2011, p. 360). Defining and treating premature ejaculation (PE) is a rather new concept, only first introduced to the mental health society in the mid 1900’s. Researchers admit defining PE can be controversial due to the lack of precise wording and limited amount of research on this topic. There are various treatment plans being developed and tested. Currently, one such treatment plan is known as psychosexual therapy with the use of specific pharmacology.

Providing PE education to mental health professionals is critical in ensuring that adequate options are provided to clients and partners dealing with PE. After educating and increasing the awareness of PE to mental health professionals, the more likely intensive research about PE will be generated.

Low self-esteem, dysfunctional relationships, anxiety, embarrassment and depression are common symptoms associated with PE (Gokce, A & Ekmekcioglu, 2010, p.2868). A man and his partner’s quality of life can be extremely affected by PE, but with the access to mental health services, these clients can find ways to deal with the challenging quality of life issues.

Keywords: premature ejaculation, Intravaginal Ejaculatory Latency Time, ejaculation
Contents

Introduction..................................................................................................................p. 4
Review of Literature.....................................................................................................p. 5
Conclusion....................................................................................................................p. 18
References....................................................................................................................p. 19
Tables/Figures/Appendix..............................................................................................p. 23
Diagnosing and Treatment Options for Premature Ejaculation

Premature ejaculation (PE) is the most common sexual dysfunction among males (Patrick et al., 2005, p 359). A few healthcare professionals will admit it is the hottest topic in sexual medicine (Jannini & Porst, 2011, p.301). Affecting 20-30% of males, premature ejaculation can be characterized by the loss or absence of ejaculatory control, interpersonal difficulty or distress, and by a short intravaginal ejaculatory latency time (IELT) (Patrick et al., 2005, p. 359). PE affects many different aspects of a male’s life including: sexual satisfaction, sexual confidence, control of ejaculation, interpersonal distress, and a male’s romantic relationships. Premature ejaculation has been associated with a range of negative psychological effects including: anxiety, depression and distress among men and their partners (Rosen and Althof et al., 2008, p. 1296). PE can cause an immense amount of stress in men and their partner’s lives, lowering their overall quality of life, self-esteem, and self-confidence. For a single male, PE may affect their motivation to find a partner. Premature ejaculation may have a significant negative to severe effect on a man’s psychological, emotional and relationship status (Premature ejaculation, 2011, p. 360)

Diagnosing PE is a challenge because many healthcare professionals have inadequate information about the criteria for diagnosing and options for treatment (Brock et al., 2009, p. 2115). Defining “premature” ejaculation is also a challenge for the question, “What is a normal ejaculation time?” The history of PE dates back to the 1930’s making premature ejaculation a rather recent discovery in the mental health world. The purpose of this paper is to help inform healthcare professionals about the diagnosing and treatment options for men and couples suffering from PE.
History of Premature Ejaculation and Treatment Options

In 1943, a healthcare professional named Schapiro suggested premature ejaculation is not only a physical issue, but a psychosomatic disturbance in which therapeutic attention should be called for (McMahon et al., 2008, p.1591). Schapiro classified PE into two categories: Primary and Secondary. Primary meaning the conditions of PE have been lifelong and secondary meaning an acquired condition. If someone is diagnosed with primary, or lifelong, PE they have always ejaculated quickly no matter the situation. Lifelong PE includes the core symptoms of early ejaculation at nearly every intercourse within 30-60 seconds in a majority of cases (80%), with nearly every sexual partner from the first encounter and on (McMahon et al., 2008). Secondary or acquired diagnoses meant a man did not always have PE, but found himself developing the problem of ejaculating at a quicker pace over time.

The treatment option in the 1940’s consisted of behavioral psychotherapy and the main technique was the stop and start technique. The start and stop technique could be completed self-manually or with a partner, arousing oneself then stopping arousal as the need to ejaculate formulated. Sometimes a squeeze in a particular area of the penis would also be added to help decrease the blood flow through the penis, ultimately slowing down the ejaculation process (Rowland & Cooper, 2011, p.347).

Before the 1940’s when behavioral techniques became popular, an on-demand topical anesthetic cream was used to delay ejaculation. This cream is said to be the oldest drug treatment for PE (McMahon et al., 2008, p.1591). During the 1960’s, medications for PE were produced and many tests were being held to gain evidence-based research for their quality.
Within the last 10 years, a medical doctor (M.D.) named Waldinger expanded the classifications for PE. Waldinger added natural variable PE and premature-like ejaculatory dysfunction (as cited in McMahon et al., 2008, p.1591). Natural variable PE can be seen as situational, or coincidental. Rapid ejaculation does not happen often, but in random situations. For example, a man having sexual relations with a highly attractive partner, and ejaculating in less than one minute would be a classic example of natural variable PE. Natural variable PE should be regarded as normal and does not need medical attention unless PE worsens or lengthens in time. Premature-like ejaculatory dysfunction occurs when a man complains of PE, but no evidence is found upon the diagnostic process. This type of PE-like ejaculatory dysfunction typically is described as one’s ejaculation within a normal time according to the definition, but a personal feeling of being “too quick.” Table 1 in appendix A illustrates the symptoms of the four PE syndromes produced by Waldinger (Serefoglu et al., 2011, p.1179). Table 1 in appendix A allows healthcare professionals to understand that PE has more than one dimension, and throughout the decades, PE criteria changed in complexity and variability. Walender’s creation (appendix A) of the four syndromes of PE has been proposed for Diagnostic and Statistical Manual of Mental Disorders Five (DSM-V) which will be published in 2013 (McMahon, et al., 2008, p.1594).

**Current Issues with Diagnosing Premature Ejaculation**

A majority of clinicians who diagnose PE use the current diagnostic definition from the DSM-IV TR which states,

A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the
sexual partner or situation, and recent frequency of sexual activity. B. The disturbance causes marked distress or interpersonal difficulty. C. The premature ejaculation is not due exclusively to the direct effects of a substance. (Althof et al., 2010, p.2949)

The main problem identified within this definition is the ambiguity of the word “short” (Kam, Han, & Lee, 2011, p.866). A short penetration could be defined by a variety of standards. According to Brock et al. (2009), on average it takes a man 6.5 minutes to ejaculate after penetration. In order to gain clarity the word “short” used in the DSM-IV TR, the intravaginal ejaculation latency time (IELT) has been used.

IELT was introduced in 1994 by Waldinger after numerous attempts to clearly define PE (McMahon et al., 2008, p.1595). Waldinger found that “a majority of men who actively seek treatment for lifelong PE, approximately 90%, ejaculate within about one minute of penetration” (McMahon et al., 2008, p.1595). Using the “about one minute” rule allows clinicians to be flexible with time. In 2007, the International Statistical Classification of Disease (Premature Ejaculation, 2008, p. 360) came to a consensus to clarify the existing definition of lifelong PE.

After carefully reviewing the literature, the committee proposed that lifelong PE is, a male sexual dysfunction characterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration, and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy. (Althof et al., 2010, p.2949).

The goal of the International Society for Sexual Medicine (ISSM) was to eliminate confusion of PE’s current definition. The major areas of criticism included the failure of evidenced-based, and
specific operational criteria, excessive ambiguity, and over-reliance on the subjective judgment of the diagnostician (Althof et al., 2010).

Table 2 in Appendix B displays all of the current definitions for PE. It is important to note that a majority of PE definitions created by individuals and/or organizations have three common constructs: a short ejaculatory latency, a lack of perceived self-efficacy or control about the timing of ejaculation and distress and interpersonal difficulty. Those three common constructs allow clinicians to get an overall idea about the diagnosing of PE, but depending on the preference of definition being used, the diagnosing criteria may differ. When you compare the ISSM definition with the Masters and Johnson’s definition, ISSM’s definition goes into further detail. Credibility and reliability of PE diagnoses would increase if national organizations could agree on one definition.

**Impact On The Man, The Partner And The Couple**

PE can affect a man’s partner just as much as the man with PE. When a couple is struggling with PE the situation is said to be asynchronous (Jannini & Porst, 2011, p.301). An asynchronous couple may have sex quite frequently, but the quality is lost or dwindled. The partner who is not suffering from PE may feel disappointed or upset for the fact their partner experiences orgasm well before them. It can be seen as if their “rhythm” or timing is off, creating a frustrating situation for the couple. “Each partner has a unique emotional and physical response to the quality of the overall sexual encounter” (Graziottin & Althof, 2011, p.304). If the quality of a couple’s sex is poor because of PE, the chances of negative emotions and a negative physical response from the partner with PE may occur. Along with many sexual dysfunctions, it is the meaning of the dysfunction that impacts the on a couple (Graziottin et al., 2011, p.306).
When the meanings of the dysfunction are hurtful or disappointing, martial issues rise for then creating a sense of sexual separation between the couple.

Studies comparing men with PE and without PE show a distinct difference in quality of life. One study conducted chose 1,587 men with and without PE and ask them questions about their personal life and their satisfaction with life in general. In order to accurately asses the men, an assessment called Premature Ejaculation Profile (PEP) was used to determine who had PE. Men with PE reported they had a higher level of stress, low confidence, reduced levels of sexual functioning and satisfaction, and a reduced level of an overall quality of life (Graziottin et al., 2011, p.305). For a single man, embarrassment can overpower them to gain the confidence to date. PE has a major impact on a man’s life, and it is also suggested that men with lifelong PE are more likely to develop erectile dysfunction because of their embarrassment of having PE.

Graziottin et al. (2011) took a look into the women’s perceptive of being a relationship with men with and without PE. Sexual desire, lubrication, and orgasms were significantly worse in the partner of men with PE, and 52% of women with PE partners admitted to orgasmic problems compared to only 23% for women without PE partners. Women who have partners with PE may ask themselves questions like: Why does he let me down every time? What can’t he control himself? Or why doesn’t he care for me? (Graziottin et al., 2011, p.306).

Since research has shown PE is not just a man’s problem, healthcare professionals should take into account their partner’s feelings and discuss treatment options and information about PE patients and their partners. In most cases, the partner was happy to join in with treatment. Involving the partner also gives the partner a chance to express his or her thoughts, feelings, and ideas towards the PE issue (Graziottin et al., 2011, p.308).

Assessment
When assessing PE with a client, a clinician will have to find their own unique style in order for their client to feel relaxed and comfortable (Leiblum, 2007, p. 227). A therapist or clinician will want to ask when the PE began and how long symptoms have lasted. Getting the patient’s sexual history helps to put together a timeline and to seek out any other sexual issues or problems. Asking about the number of partners and sexual performances with particular partners helps to clarify the degree of performance anxiety, the narrowness or broadness of his sexual repertoire, his cognition and affect, what happens after he ejaculates and the response of the partner to his dysfunction (Althof, 2007, p. 227).

After going through extensive detail about his current and past sexual relationships and the effects of PE on those relationships, a clinician may ask about his level of awareness as it relates to his sexual arousal. Being aware of one’s sexual arousal may trigger a PE client to use a different method of stopping ejaculation. A clinician may then ask about successful attempts. A clinician does not want to recommend repeated techniques that have had failed results.

The last portion of the assessment is questions for the partner and couple. An overview of questions should be asked about their sexual and non-sexual relationship. Questions for the partner may include: Do you have any sexual dysfunctions? Are you willing to participate in treatment planning? Do you engage in helping your partner delay ejaculation or do you encourage rapid ejaculation? (Leiblum, 2007, p. 227). Questions for the couple help the clinician find strengths and weakness inside the relationship in order to formulate the best outcome and treatment plan.

**Treatment Options**

Out of the 20-30% of men who suffer from premature ejaculation, only 1-12% self-reported males report receiving treatment (Patrick et al., 2005, p. 359). Seeking out treatment for
PE can be embarrassing for males, and they also may not know where to find treatment options. There are treatment options in forms of medical drugs, therapy, or a combination of these treatments (Steggall, Fowler, & Pryce, 2008, p.365). Through the early 1990’s, behavioral psychosexual therapies were considered the treatment of choice for men, but more recently pharmacologic drugs have found to delay ejaculation (Althof, 2006, p. 328). One problem with administering pharmacological drugs is dealing with side effects. These side effects may include: nausea, diarrhea, vaginal numbness or addiction (Porst, 2011 p.336).

One treatment option to treat both the biological and psychological problem of premature ejaculation is psychosexual therapy. Goals of psychosexual therapy include: learning techniques to control ejaculation, gaining confidence in sexual performance, resolving interpersonal issues, identifying or resolving interfering feelings or thoughts, reducing performance anxiety, modifying rigid sexual repertories, and increased interpersonal communication (Althof, 2006, p. 329). In the study conducted by Rosen and Althof in 2008, they concluded: “PE is a condition with a high level of psychological distress that impacts the man and his partner and with availability of effective treatments, PE’s impact on the quality of life and relationships should be significantly reduced.” (P. 1305 )

**Psychotherapy**

Psychosexual or psychotherapy alone can treat premature ejaculation and is a well-balanced approach for curing PE in a male’s life. (Rowland & Cooper, 2011). The emotional, physical, and relationship burdens associated with PE are discussed in psychosexual therapy. The emotional and relationship aspects of distress due to PE can be discovered and discussed through talk therapy, and specific sexual techniques are taught to work on the physical distress (Althof, 2006, p. 328). Presented in the next section are contemporary approaches to psychosexual
therapy using psychotherapy interventions from 4 domains: behavioral, cognitive, affective, and relational.

In 1970, Masters and Johnsons studied and implemented the idea that PE is a learning/behavioral problem. In a behavioral theory, the PE response is developed through conditioning, and in order to change the behavior a different stimulus could be applied creating reinforcement (Rowland & Cooper, 2011, p.347). Masters and Johnson also wanted sexual partners to be included in the treatment, in which they created the “start-stop” method. The technique involves engaging in sexual foreplay until the point of ejaculation. Next the client will squeeze the head of the penis or stop sexual interaction to slow down the ejaculation process and try to decrease the urge to ejaculate. After sensation decreases and urge level lowers, the couple begins foreplay again. The partner can get involved by stimulating his or her partner by using their hand, oral sex, or slow penetration. The man and his partner can use verbal or physical communication with one another to let the each other know when the point of ejaculations is about to occur, and then stop and/or squeeze. This technique has generally shown moderate results in terms of both improved sexual satisfaction and long-term efficacy (Rowland et al., 2011, p.347).

A cognitive approach is going to help reshape the interpretation of perceptions and feelings of ejaculation by improving communication skills; whether it is between a man with PE and his partner or personal communications between-men with PE with non-sexual conversations. Sexual skills and self-confidence are taught in order to help reduce anxiety associated with sexual activity (Rowland et al., 2011, p.347). Faulty beliefs and distorted thinking by men who suffer from PE are two common symptoms. Using cognitive therapy, clinicians can assist men in working through unrealistic and distorted thoughts. For example,
some men may feel badly that they cannot have sex with a woman for a long time, thinking that “real” sex equals long sex. They may also believe or think their partner wants a long, full on penetration sex session. “One key goal of cognitive therapy is for the patient to learn to refute faulty beliefs and replace them with more accurate and beneficial ones” (Rowland et al., 2011, p.348).

Sometimes men who suffer from PE will have high anxiety about sexual encounters because of their fear of ejaculating too quickly. They may also have negative thoughts or emotions geared towards sexual encounters. Negative thinking or distorted thinking sometimes reinforces negative thinking or emotions which in turn make the man with PE feel worse. When a man with PE constantly thinks about everything that may go wrong in a sexual encounter, overtime his thoughts can be reinforced by his PE problem. Desibles (DESensitizing Irrational BELiefs), Counters, and Rational-Emotive Behavioral Therapy (REBT) are three different methods to help eliminate distorted thinking (Rowland et al., 2011, p.348). Desibels, is based on research indicating that patients’ awareness and mindfulness of their disturbance in thinking will lower their feelings of distress (Rowland et al., 2011, p.348). Men with PE who use desibels learn to take time out of their day, usually ten minutes, to stop and think about changes in their thinking that are achievable. The changes of thinking will all be based around their PE. They will take one identified distorted thought and change the thought into a more positive and constructive one (Rowland et al., 2011, p.348).

Counters are similar to desibels, but instead of thinking about the changes to be made, a patient will identify the distorted thought orally and in writing (Rowland et al., 2011, p.348). A man with PE who wants to use the counter method will write down and say out loud his ideas to counterargument the identified irrational belief. “Counters must directly contradict the false
belief; be believable statement of reality; be concise; be created and owned by the patient; be stated (externally or head mentally) with assertion and emotional intensity” (Rowland et al., 2011, p.348). The more counters written down and spoken about, the more of the man’s irrational thoughts are worked through. Counters can be done in therapy and/or used as homework.

The final option to eliminate distorted thinking is REBT, which is a therapy that dates back to 1955. The main goal of REBT is to replace irrational thoughts with rational thoughts. “REBT is based on the principles that a person’s past experiences shape his or her belief system and thinking patterns (Rowland et al., 2011, p.349).” Men with PE tend to form irrational thinking patterns which results in extreme emotional distress and irrational ideas. For example, a man with PE who has distorted thinking may have the thought that he must be the perfect lover in order to satisfy his partner or be “the man.” When using REBT, the first phase is to recognize, record, analyze, and modify irrational cognitions. The second phase is to identify and modify the dysfunctional attitudes that encourage irrational cognitions. Using a man who has the distorted thinking that he must be the perfect lover, REBT would help him throw away his irrational thought of perfection and replace it with thoughts that there is no such thing as a perfect lover. Identifying and then making the change will lower anxiety and increase realism.

“A short term psychotherapy approach working with men and couples of PE, which aims to resolve unpleasant emotions by considering these emotional states as sources of useful information is called emotion-focused therapy (EFT)” (Rowland et al., 2011, p.349). When using EFT one keeps the main goals as a prime focus: promote emotional awareness, regulate emotions, and transform negative emotion into positive emotion. A man with PE may have numerous emotions attached with their PE issue, and sometimes only one emotion is being
expressed. When only one emotion is being expressed, and in most PE cases the emotion is negative, the other emotions are being avoided. All emotions are equally important. EFT is a slow process, but the drive behind this theory is that all emotions concerning PE must be dealt with prior to any behavioral or cognitive change. (Rowland et al., 2011, p.349).

In the last domain, relationship issues encourage the couple to work as a team. There is a higher success rate for PE when both partners are involved in the treatment process. Whether or not there is a dysfunction, having a strong communication between partners is extremely important for a long-lasting commitment. Besides a strong commitment to help one another with PE issues, there should be a strong relationship between the partners and their physician or therapist. The therapist or physician should keep a close monitor on the interaction between the couple to be able to catch areas of improvement in their communication process. The two main ideas of helping improve relationship issues dealing with PE are to heighten communication skills and learning relationship-orientated techniques. Both are proven to improve overall sexual satisfaction (Rowland et al., 2011, p.350).

**Pharmacotherapy**

Using medications to treat PE is another treatment option. In a recent study, 26% of men with PE used on-demand selective serotonin reuptake inhibitor (SSRI) therapy, while 25% of men with PE used a daily SSRI (Porst, 2011, p.335). On-demand SSRI’s are usually taken a few hours before intercourse, compared to a daily SSRI which is taken each day before breakfast. The debate between which one works better depends on the type of PE diagnoses. There is a difference in treatment options when comparing lifelong PE to acquired PE.

Paroxetine is a popular SSRI used for lifelong PE. It is taken orally in pill form, each day before a man’s first meal. When a man first takes Paroxetine the results are poor, but when taken over time there is an increase in serotonin within the synapses creating a more ejaculatory-
delaying effect when compared to initial intake of Paroxetine (Alghobary, El-Bayoumy, Mostafa, El-Hassanin, 2010, p.2864). Common side effects of Paroxetine are headaches, fatigue, mild nausea, loose stool, and dry mouth.

An on-demand medication receiving attention for PE is Tramadol. Tramadol is in pill form and is taken 2-3 hours before intercourse (Alghobary et al., 2010, p.2863). Tramadol is taken for 2 periods of 6 weeks meaning a grand total of a 12-week treatment process. Tramadol has side effects that include: dyspepsia, somnolence, and a potential for drug addiction (Porst, 2011, p.336). Tramadol is best suited for acquired PE due to the side effects of addiction.

Dapoxetine is a recently developed short-acting SSRI and is currently being approved to treat both lifelong PE and acquired PE (Porst, 2011, p.337). Dapoxetine was shown to improve IELT from less than one minute to 3.4-4.3 minutes. Another benefit to Dapoxetine is the SSRI starts to work 1.3 hours after taken, and diminished from the body within 24 hours (Porst, 2011, p.337). Nausea, diarrhea, dizziness, and headaches are all side effects of Dapoxetine. Dapoxetine is also considered quite expensive.

The most crucial step in making the decision to use medications as a treatment option for PE is correct dosage. In order to get a correct dosage, the IELT, duration of PE, and type of PE must be discussed and decided (Porst, 2011, p.340). In the next section, the importance of follow-up and dosages is discussed. “PE patients should highly consider sexual counseling as a first treatment option” (Porst, 2011, p.340).

Follow-up

Healthcare professionals should conduct a follow-up session to achieve the best outcome in treatment (Moncada, 2011, p.353). One reason why a follow-up session can be crucial for a client with PE is because clients may become confused once treatment begins. One study found
36% of patients did not know the purpose of their new medication or the name of their medication (Moncada, 2011, p.354). The study also found that 44% of patients did not know the correct dosage and 32% did not know how often to take the new medication, and 88% did not know anything about possible side effects (Moncada, 2011, p.354). Therapists should work closely with the physician who prescribed medication for PE patients. Stronger communication between the team of healthcare professionals usually generates a better the outcome for the man or couple suffering from PE.

“ALLOW” is a useful model for healthcare professionals who may not be comfortable talking about sexual-health issues, or unsure about the follow-up process (Moncada, 2011, p.357). Each letter of ALLOW stands for a step. A, ask, involves asking the patents about their sexual activity. L, legitimize, involves acknowledging the patients problems and that sexual dysfunction is an important issue. L, limitations, invites the clinician to evaluate their own interest and ability to work with patients who report a sexual problem. O, open, involves the clinician opening up the issues for further discussion and diagnostic evaluation or referral. W, work, involves working with the patient to develop a treatment plan (Moncada, 2011, p. 357).

A 4-week follow up is the standard amount of time to check in with clients, and a clinician should review the following: evaluation of client’s or couple’s entire progress, assessment of how successful or unsuccessful treatment has been going, discussion of side effects, and exploration of psychological concerns (Moncada, 2011, p.356). After the first initial check-up, scheduling future appointments to enhance a strong and open communication between the client, couple and clinician is recommended. “Regular and effective follow-up visits can facilitate the development of a stable partnership between the clinician and patient that, in turn, enhances the likelihood of a successful clinical outcome” (Moncada, 2011, p.358).
Conclusion

Premature Ejaculation is a sexual disorder that affects a man and his partner. The psychological effects of PE can be detrimental to man’s quality of life and the overall quality of his romantic relationships. Through the use of medications and psychotherapy, PE can be treated. Mental health professionals who have been well educated about the diagnosing and treatment planning of PE have the capabilities of helping couples and men feel better about their sexual and mental health pertaining to their PE.

As mental health clinicians are educated about the realm of PE, it is in their professional responsibility to increase empirical research studies to help clarify the definition of PE and find resourceful treatment options. Increasing amounts of experiments, research and results about PE will bring greater awareness to mental health professionals. The increasing awareness will help clinicians feel confident to discuss PE issues with men and couples. Building an empathic, well-educated and caring relationship with a couple or man with PE will increase the success of treatment.
References


Appendix A

Table 1 Summary of the symptoms of the four premature ejaculation syndromes used in the classification for males with complaints of ejaculating prematurely (adapted from Waldinger)

<table>
<thead>
<tr>
<th>Lifelong PE</th>
<th>Acquired PE</th>
<th>Natural variable PE</th>
<th>Premature-Like ejaculatory dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the majority of cases (80%)</td>
<td>IELT is short (Less than 2 min.)</td>
<td>Ejaculation time may be short or normal</td>
<td>IELT is in the normal range or may even be of longer duration</td>
</tr>
<tr>
<td>Within 30-60 seconds or between 1-2 minutes</td>
<td>Early Ejaculation occurs at some point in man’s life</td>
<td>Early ejaculation are inconsistent or irregular</td>
<td>Subjective perception of consistent or inconsistent rapid ejaculation</td>
</tr>
<tr>
<td>From the first sexual encounter</td>
<td>The man had normal ejaculation experiences before</td>
<td>Ability to delay ejaculation may be diminished or lacking</td>
<td>Ability to delay ejaculation may be diminished or lacking</td>
</tr>
<tr>
<td>With nearly every women</td>
<td>The impression or diminished control of ejaculation</td>
<td>The dysfunction may be the result of urological/thyroid dysfunction or psychological/relationship problems</td>
<td>Imagines early ejaculation or lack of control of ejaculation</td>
</tr>
<tr>
<td>Ejaculation occurs too early nearly in each intercourse</td>
<td>The onset is either sudden or gradual</td>
<td>Psychotherapy should be considered as the first line treatment</td>
<td>The preoccupation is not better accounted for by another mental disorder</td>
</tr>
<tr>
<td>Remains rapid through Lifetime (neurobiological/Genetic cause)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source:* (Serefoglu, E., Yaman, O., Cayan, S., Asci, R., Orhan I., Usta I., Ekmekcioglu, O., Kendirci, M., Semerci, B. & Kadioglu, 2011)

Appendix B

Table 2 Definitions of Premature Ejaculation

<table>
<thead>
<tr>
<th>Definition</th>
<th>Source</th>
</tr>
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<tbody>
<tr>
<td>A male sexual dysfunction characterized by ejaculation that always or nearly always occurs prior to or within one minute of vaginal penetration, and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy.</td>
<td>International Society of Sexual medicine, 2008</td>
</tr>
<tr>
<td>Persistent or recurrent ejaculation with minimal sexual stimulation, before, on, or shortly after penetration and before the personal wishes it. The condition must also cause marked distress or interpersonal difficulty and cannot be due exclusively to the direct effects of a</td>
<td>DSM-IV-TR, 2000</td>
</tr>
</tbody>
</table>
For individuals who meet the general criteria for sexual dysfunction, the inability to control ejaculation sufficiently for both partners to enjoy sexual interaction, manifest as either the occurrence of ejaculation before or very soon after the beginning of intercourse (if a time limit is required, before or within 15 seconds) or the occurrence of ejaculation in the absence of sufficient erection to make intercourse possible. The problem is not the result of prolonged absence from sexual activity.

| Substance. | 
| --- | --- |
| The inability to control ejaculation for a “sufficient” length of time before vaginal penetration. It does not involve any impairment of fertility, when intravaginal ejaculation occurs. | European Association of Urology, Guidelines on Disorders of Ejaculation 2001 |
| Persistent or recurrent ejaculation with minimal stimulation before, on or shortly after penetration, and before the person wishes it, over which the sufferer has little or no voluntary control, which causes the sufferer and/or his partner bother or distress. | International Consultation on Urological Diseases, 2004 |
| Ejaculation that occurs sooner than desired, either before or shortly after penetration, causing distress to either one or both partners. | American Urological Association Guidline on the Pharmacologic Management of Premature Ejaculation, 2004 |
| The man does not have voluntary, conscious control, or the ability to choose in the most encounters when to ejaculate. | Metz and McCarthy |
| The Foundation considers a man a premature ejaculator if he cannot control his ejaculatory in at least 50% of their coital connections. | Masters and Johnson |
| Men with IELT of less than 1 minute (belonging to the 0.5 percentile) have “definite” premature ejaculation, whereas men with IELTs between 1 and 1.5 minutes (between .5 and 2.5 percentile) have “probable” premature ejaculation. In addition, an additional grading of severity of premature ejaculation should be defined in terms of associated psychological problems. | Waldinger |

Source: Althof, S., Abdi, C., Dean, J., Hackett...2010.