REVIEW ARTICLE

THE IMPACT OF PSYCHOLOGICAL FACTORS ON EJACULATION DISORDERS (PREMATURE EJACULATION)

Wpływ czynników psychologicznych na zaburzenia wytrysku (wytrysk przedwczesny)

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Abstract

Introduction: Premature ejaculation is widely recognized as the most common male sexual dysfunction, affecting up to 30% of the sexually active male population. As a taboo subject, it often goes unreported. Premature ejaculation has a complex aetiology, encompassing both congenital and acquired causes, with psychosocial and biological factors playing a significant role. **Objectives:** The main aim of this article was to analyse the potential psychological factors contributing to the development of premature ejaculation and to emphasize the need for a comprehensive clinical interview to properly differentiate the underlying causes of the dysfunction. **Methods:** This article is a review based on the analysis and synthesis of available scientific literature and clinical guidelines on the epidemiology, aetiology, diagnosis, and treatment of premature ejaculation. The focus was on factors contributing to acquired premature ejaculation, with particular emphasis on psychological mechanisms. **Results:** The aetiology of acquired premature ejaculation has been shown to be multifactorial and characterized by the interaction between biological and psychological factors. Sympathetic nervous system overactivity and an impaired excitation/inhibition balance is the common denominator of these mechanisms. Furthermore, we found a significant correlation between premature ejaculation and poor mental health. Unfortunately, discrepancies in diagnostic timing criteria hinder standardization. Causal treatment should be used for acquired premature ejaculation, and if insufficient, pharmacotherapy should be initiated. **Conclusions:** Premature ejaculation is a sexual dysfunction requiring an interdisciplinary and personalized approach. It is crucial to distinguish acquired from lifelong premature ejaculation based on a detailed clinical interview. Psychotherapy is an essential component of therapy, regardless of the aetiology of the dysfunction. Openness to this topic and interdisciplinary care are key to improving patients' quality of life.

Streszczenie

Wstęp: Wytrysk przedwczesny jest powszechnie uznawany za najczęstszą dysfunkcję seksualną mężczyzn, dotykającą nawet 30% populacji aktywnej seksualnie. Jako problem nadal obciążony tabu często pozostaje nieraportowany. Zaburzenie to ma złożoną etiologię, obejmującą zarówno podłoże wrodzone, jak i nabyte, w którym istotną rolę odgrywają czynniki psychospołeczne i biologiczne. **Cele:** Głównym celem pracy była analiza możliwych czynników psychologicznych, które mogą przyczyniać się do rozwoju nabytego wytrysku przedwczesnego. Ponadto celem było uwrażliwienie klinicystów na konieczność przeprowadzenia szczegółowego wywiadu w celu prawidłowego różnicowania przyczyn dysfunkcji. **Metodyka:** Artykuł ma charakter przeglądowy i opiera się na analizie i syntezie dostępnej literatury naukowej oraz wytycznych klinicznych dotyczących epidemiologii, etiologii, diagnostyki i leczenia wytrysku przedwczesnego. Skoncentrowano się na czynnikach wpływających na nabyty wytrysk przedwczesny, ze szczególnym uwzględnieniem mechanizmów psychologicznych. **Wyniki:** Analiza piśmiennictwa wskazuje, że etiologia nabytego wytrysku przedwczesnego jest wieloczynnikowa i charakteryzuje się wzajemnym oddziaływaniem czynników biologicznych i psychologicznych. Wspólnym mianownikiem tych mechanizmów jest nadaktywność układu współczulnego i zaburzona równowaga między pobudzeniem a hamowaniem. Ponadto stwierdzono istotną korelację wytrysku przedwczesnego ze złym stanem psychicznym. W diagnostyce istnieją rozbieżności w kryteriach czasowych, co utrudnia standaryzację. Leczenie nabytego wytrysku przedwczesnego powinno być ukierunkowane na przyczynę. W przypadku niewystarczającej skuteczności postępowania przyczynowego stosuje się farmakoterapię. **Wnioski:** Wytrysk przedwczesny jest dysfunkcją seksualną, której leczenie wymaga podejścia interdyscyplinarnego i spersonalizowanego. Kluczowe jest rozróżnienie wytrysku przedwczesnego nabytego i wrodzonego na podstawie szczegółowego wywiadu. Psychoterapia stanowi niezbędny element terapii, niezależnie od etiologii dysfunkcji. Otwartość w podejmowaniu tego tematu i interdyscyplinarna opieka są kluczem do poprawy jakości życia pacjentów.

Keywords: sexual health; premature ejaculation; sexology; SSRIs; dapoxetine

Słowa kluczowe: zdrowie seksualne; wytrysk przedwczesny; seksuologia; SSRI; dapoksetyna

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Introduction

Sexuality is an integral aspect of human life. When analysing overall well-being, sexual health cannot be overlooked. However, issues related to sexuality and sexual activity remain taboo in many settings, which may discourage affected individuals from seeking help. Sexual problems should not be underestimated as they may indicate a serious underlying organic disorder. When evaluating sexual difficulties, both somatic and mental health should be considered, as many sexual dysfunctions stem from psychological factors. Premature ejaculation (PE) is one of the most common sexual disorders in men. It may be classified as lifelong or acquired, and its aetiology is multifactorial.

We aimed to investigate the psychological factors that may contribute to the development of acquired premature ejaculation (APE), emphasizing the importance of a comprehensive clinical interview conducted by physicians and psychologists, which may help determine whether the patient's symptoms arise from psychological or genetic factors.

Materials and methods

This narrative review was conducted in accordance with the principles of literature synthesis in biomedical research. A comprehensive search of PubMed, Scopus, and Web of Science databases was performed to identify review papers published between 1998 and 2025. The search strategy combined relevant keywords and Medical Subject Headings (MeSH), including "sexual health," "premature ejaculation," "mental health," "sexology," "selective serotonin reuptake inhibitors (SSRIs)," and "dapoxetine".

Inclusion criteria:
- systematic reviews, meta-analyses and narrative reviews on PE;
- papers presenting data on epidemiology, risk factors, diagnostic methods, screening tools or treatment strategies;
- publications in English in peer-reviewed journals.

Exclusion criteria:
- basic research, case reports and conference abstracts;
- non-peer-reviewed publications and preprints.

Titles and abstracts of all identified records were screened to exclude irrelevant publications. The full texts of articles meeting the eligibility criteria were then reviewed in detail. Data from the included publications were extracted and synthesized narratively, integrating international findings and, where possible, highlighting evidence relevant to the Polish context. No formal tool was used to assess the methodological quality of the included reviews.

Epidemiology

Reliable data on the prevalence of PE remain limited, as sexual problems are often underreported, making it difficult to estimate the actual scale of the condition. Nevertheless, PE is widely regarded as the most common sexual dysfunction among men worldwide. Epidemiological estimates vary, with approximately 30% of men aged 18–59 years reporting PE symptoms [2]. Some studies have reported prevalence rates of up to 75% among sexually active men [3–5]. Although PE can occur at any age, it is most frequently reported by young men aged 18–30 years [6]. However, the majority of epidemiological studies of PE have been criticized for relying on self-reported assessments or diagnostic methods with limited validation. Differences in reported prevalence may therefore reflect variation in study design, assessment instruments, diagnostic criteria, and the age distribution of the study populations [7].

Aetiology

The aetiology of APE is complex and multifactorial, involving interactions among biological, neurophysiological, endocrine, inflammatory, genetic, behavioural, relational, and psychological factors [8].

Among the biological contributors, disturbances in serotonergic neurotransmission appear to play a prominent role. Reduced activity of 5-HT2C and 5-HT1B receptors accompanied by increased activity of 5-HT1A receptors has been linked to a shorter intravaginal ejaculation latency time (IELT) [9]. The ability of selective serotonin reuptake inhibitors (SSRIs) to prolong IELT further supports the role of serotonin in the inhibitory regulation of ejaculation [9].

Endocrine factors are also important players. Clinical studies suggest that hyperthyroidism can shorten ejaculation latency and that appropriate treatment of thyroid dysfunction may restore normal ejaculatory control [10]. Other hormonal abnormalities, including hyperprolactinaemia, low testosterone, and altered pituitary hormone levels, may modulate sympathetic and dopaminergic activity, thereby affecting the ejaculatory threshold [10].

Urological and inflammatory conditions represent another aetiological factor. It has been shown that chronic prostatitis and chronic pelvic pain syndrome can lead to APE due to hypersensitivity of sensory receptors in the prostate, urethra and penis [11]. Persistent stimulation of the afferent pudendal fibres may promote premature activation of the ejaculatory reflex. Consequently, the time required to initiate the emission phase may be reduced.

Metabolic and vascular factors may also contribute to the pathogenesis of APE. Metabolic syndrome, insulin resistance, and obesity have been associated with increased adrenergic activity and endothelial dysfunction, which may impair smooth muscle function within the sperm ducts [12]. Impaired tissue perfusion and endothelial dysfunction, often occurring alongside hypertension and atherosclerosis, may also contribute to erectile dysfunction (ED) and reduced ejaculation latency; however, evidence for their direct impact on PE remains inconclusive [13].

Genetic determinants of PE have also been described, particularly polymorphisms in the serotonin transporter-linked polymorphic region (5-HTTLPR) and genes encoding the 5-HT2C receptor, which may increase susceptibility to PE [14].

From a behavioural perspective, much importance is attributed to masturbation habits and early sexual experiences. Men who developed a habit of rapid masturbation during adolescence, often due to stress, time pressure, or fear of being interrupted, may have conditioned their bodies to reaching ejaculation quickly [15]. This phenomenon can be understood through classical conditioning: sexual stimuli become associated with immediate relief of sexual tension, which may facilitate reflexively accelerated ejaculation during adulthood [15, 16].

Relational factors are another important aspect. Men with PE may be more likely to experience difficulties communicating with their partner, emotional conflicts, reduced intimacy, and perceived partner dissatisfaction with their sexual life [17]. When openness and trust are limited, men may feel pressure to "meet expectations," which increases emotional tension and activates stress responses. Increased sympathetic nervous system activity during intercourse results in a faster emission phase and shorter ejaculation time [18].

Among psychological contributors, fear related to sexual intercourse and performance anxiety may play a central role. Men with APE are more likely to show concern about being judged by their partners and fear of sexual "failure". This anxiety can increase muscle tension, adrenaline and noradrenaline release, as well as activation of spinal pathways involved in the ejaculatory reflex [19, 20]. Studies have shown that intense anxiety about sexual performance may be associated with a shorter IELT and reduced perceived control over ejaculation [20]. Intrapsychic conflicts, such as tension between the desire for control and fear of losing it, as well as guilt, shame, or ambivalence about one's sexuality, may represent additional mechanisms involved in APE [21]. In these circumstances, rapid ejaculation may function as an unconscious means of reducing emotional tension and avoiding prolonged exposure to an anxiety-provoking situation.

Psychosexual literature describes the phenomenon of "rapid ejaculation as an escape from intimacy". This mechanism has been observed particularly in men characterized by excessive emotional control and difficulty communicating emotions [18–21].

Equally important are established cognitive beliefs about sexuality and one's sexual performance. Men with PE may be more likely to exhibit perfectionistic and catastrophic thinking patterns, such as "I must always satisfy my partner" or "If I cannot last long, I have failed." [20–22]. During intercourse, men with PE may focus excessively on monitoring their own sexual responses, a process known as spectatoring, which increases tension, shortens the duration of sexual arousal, and reduces the ability to inhibit ejaculation [22, 23]. This mechanism creates a vicious circle: the greater the expectations and fear, the stronger the physiological tension and the faster the ejaculation.

These biological, hormonal, inflammatory, genetic, behavioural, relational, and psychological factors do not act in isolation but rather interact. Increased sympathetic nervous system activity and an imbalance between excitatory and inhibitory mechanisms regulating ejaculation seem to be a common pathway. However, there is still no clear data defining the relative contribution of individual factors to PE [13]. Table 1 summarizes potential risk factors and their proposed roles in the development of APE.

Diagnostic criteria

According to published studies, PE is the most common sexual dysfunction among men [24]. Its estimated prevalence is approximately 20–30%; however, these figures may vary as definitions and diagnostic terminology differ across studies [25]. In Poland, PE is diagnosed using the World Health Organization's International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Under this classification, premature ejaculation (F52.4) is defined as the inability to control ejaculation sufficiently for both partners to enjoy sexual interaction. In some cases, ejaculation may occur before vaginal penetration or before a full erection is achieved.

Specific diagnostic criteria must be met in order to diagnose PE. Criterion A encompasses some general requirements for sexual dysfunction, including difficulty engaging in sexual activity in a manner consistent with one's desires; recurrent, though not necessarily persistent, pattern of symptoms; symptom duration of at least six months; and the absence of an alternative explanation, such as mental or somatic disorder, or the effects of pharmacotherapy. Criterion B refers to persistent inability to delay ejaculation sufficiently to allow satisfactory sexual activity; ejaculation may occur before or immediately after penetration begins, with the penetration phase lasting no longer than approximately 15 seconds. In some cases, ejaculation may occur despite an erection that is insufficient for penetration. Criterion C specifies that the

Tabela 1. Możliwe czynniki ryzyka i ich wpływ na rozwój nabytego wytrysku przedwczesnego

Factors	Examples	Mechanism underlying APE
Neurophysiological	Dysregulation of the serotonergic system (reduction of 5-HT2C and 5-HT1B receptor activity, increase of 5-HT1A activity)	Imbalance between excitation and inhibition of the ejaculatory reflex; excessive activation of spinal centres shortening IELT
Endocrine	Hyperthyroidism, hyperprolactinemia, low testosterone, pituitary hormone disorders	Excessive adrenergic activity, increased sympathetic stimulation, impaired dopaminergic regulation
Inflammatory and urological	Chronic prostatitis, chronic pelvic pain syndrome	Hypersensitivity of the prostate and urethra sensory receptors; accelerated activation of the ejaculatory reflex arc
Metabolic and vascular	Metabolic syndrome, obesity, insulin resistance, hypertension, atherosclerosis	Increased adrenergic activity, endothelial and perfusion disorders affecting the function of the smooth muscle of the vas deferens; possible co-occurring erectile dysfunction
Genetic (predisposing)	Polymorphisms of the serotonin transporter gene (5-HTTLPR) and 5-HT2C receptors	They may predispose to reduced ejaculatory control by affecting the sensitivity of the serotonergic system; however, they are not a direct cause of APE
Behavioural	Early, rapid masturbation when stressed or in a hurry	Classical conditioning – the consolidation of the pattern of rapid ejaculation in response to sexual stimuli
Relational	Conflicts between partners, lack of intimacy, low sexual satisfaction of the partner	Increased emotional tension and pressure to meet expectations; activation of the sympathetic nervous system and shortening of the emission phase
Psychological – anxiety and tension	Fear of intercourse, performance anxiety	Increased muscle tension, adrenaline and noradrenaline secretion, sympathetic hyperactivity; shortened IELT and loss of control
Psychological – intrapsychic conflicts	Contradiction between the need for control and the fear of losing it, guilt, shame, avoidance of closeness	Ejaculation as an unconscious form of reducing emotional tension; avoiding anxiety-generating situations by quickly ending the sexual intercourse
Psychological – beliefs and attention	Perfectionistic, catastrophic beliefs ("I have to please my partner"), excessive monitoring of reactions ("spectatoring")	Increased self-awareness, increased physiological tension, shortened arousal phase and loss of control over ejaculation
Integrating factors	Interactions between biological, hormonal and psychological factors	Sympathetic nervous system overactivity and an imbalance between the mechanisms of ejaculation stimulation and inhibition

disorder should not be attributable to a prolonged period of sexual abstinence.

ICD-10 classifies PE as a sexual dysfunction not caused by an organic disorder, underscoring the need to consider both psychological and physiological factors during diagnosis [26]. The International Classification of Diseases, 11th Revision (ICD-11), which has not yet been officially translated into Polish, is another relevant classification framework. It provides a similar definition, describing male early ejaculation as ejaculation that happens before or very soon after penetration or other sexual stimulation, with little or no control over when it occurs. The condition may occur sporadically or persist for several years.

Male early ejaculation is classified as a sexual dysfunction and assigned the code HA03.0. For the condition to be diagnosed as a sexual dysfunction, symptoms must persist or recur for at least several months. Cases in which the symptoms are attributable to another condition, such as a spinal cord injury, should be excluded. Symptoms must occur frequently, vary in severity, and be associated with clinically significant distress. PE may be classified as primary (lifelong, LPE) or acquired (when it develops later in life). It may also be categorized as situational (occurring only in specific circumstances), or generalized (occurring consistently regardless of the situation) [27].

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), provides specific time-based criteria for assessing the severity of PE. PE is classified as mild when ejaculation occurs within 30–60 seconds of penetration, moderate when it occurs within 15–30 seconds, and severe when it occurs within 15 seconds. DSM-5 defines PE as a persistent or recurrent pattern of ejaculation occurring within approximately one minute of vaginal penetration during partnered sexual activity, before the individual desires it. Additionally, diagnosis requires that the general criteria for sexual dysfunction be met: symptoms must occur during all or almost all sexual encounters (approximately 75–100%), persist for at least six months, and cause clinically significant distress. Also, the dysfunction cannot be better explained by another mental disorder, relationship difficulties, substantial stressors, substance use, including medications, or a medical condition [28].

Treatment

The choice of treatment for PE should be guided by the underlying cause and mechanisms of the dysfunction. A thorough clinical and psychosexual history can help identify the principal contributing factors and direct the patient toward an appropriate therapeutic approach. Distinguishing between APE and LPE is an essential step. Pharmacotherapy often plays an important role in APE, whereas psychotherapeutic interventions may be particularly useful in LPE.

Available treatment modalities for PE include pharmacotherapy and psychotherapeutic interventions. Selective serotonin reuptake inhibitors (SSRIs) are among the most extensively investigated pharmacological options. SSRIs, which are typically prescribed for the treatment of mood disorders, including depression, prove most effective. Used alone in low doses or in combination with psychosexual counseling, they are widely accepted as first-line treatment for LPE, and are recommended by leading urological guidelines. Dapoxetine fills an important gap in the management of PE, offering a safer and more convenient treatment [29]. Other treatments include topical anaesthetics and tricyclic antidepressants [30]. However, SSRIs generally produce only a temporary extension of IELT, with symptom recurrence shortly after treatment discontinuation [31]. Furthermore, many pharmacological interventions for PE are experimental or prescribed off-label.

Behavioural therapy, sex therapy in particular, is a treatment method for PE characterized by fewer adverse effects and lower costs compared to pharmacotherapy. Its primary goal is to improve self-confidence and reduce anxiety and depression by acquiring sexual skills that may help delay ejaculation. Although behavioural therapy may be effective in 45–65% of patients in the short term, its long-term effects remain uncertain [32].

Psychotherapeutic and behavioural interventions aim to improve ejaculatory control by helping men (and their partners) to achieve the following goals:

- **self-confidence**: gaining confidence in one's sexual performance;
- **anxiety reduction**: reducing sex-related anxiety;
- **changing sexual behaviour patterns**: modifying rigid sexual behaviour patterns;
- **intimacy**: overcoming intimacy barriers;
- **relationships**: resolving interpersonal issues that trigger and maintain dysfunction;
- **emotional acceptance**: coming to terms with feelings and thoughts that interfere with sexual function;
- **communication**: improving communication in a relationship.

In summary, the management of APE requires an individualized approach that considers the aetiology, severity, and coexisting sexual dysfunctions.

Consequences

As the diagnostic criteria outlined above indicate, PE does not necessarily have an organic cause or occur from the beginning of an individual's sexual life. If the dysfunction is acquired or occurs only under specific circumstances, psychological factors potentially associated with its onset and persistence should be considered. Research indicates a significant correlation between PE and poor mental health [33]. Men with PE report significantly higher levels of anxiety and depression compared to healthy controls. High anxiety levels are also associated with greater symptom severity: higher anxiety levels correspond with a shorter ejaculation latency. This suggests a potentially bidirectional relationship between mental health and PE: anxiety may contribute to the development or persistence of PE, while PE itself can intensify anxiety, reduce mental well-being, and create a vicious emotional cycle [19–33].

Mitigating anxiety is therefore important both for lowering the risk of PE and for supporting its treatment. PE can substantially reduce the quality of life for both the affected person and their partner. It is frequently associated with psychological distress, lower self-esteem, and increased anxiety; it may also contribute to ED, decreased libido, and relationship problems [34]. Patients with PE also experience a lack of self-confidence in sexual situations, reduced self-esteem, lack of sexual satisfaction and interpersonal problems.

Despite these far-reaching psychological, emotional, and interpersonal consequences, many men remain reluctant to discuss PE with a healthcare professional. Nevertheless, effective, evidence-based treatments are available and can significantly improve the quality of life of patients with sexual dysfunctions.

Discussion

A key point in the discussion of APE is distinguishing it from the lifelong form. According to the literature, APE is characterized by a sudden or gradual IELT reduction following normal ejaculatory control, typically in association with an identifiable underlying cause [8]. However, standardizing the definition of APE and establishing uniform IELT criteria remain challenging, given the subjective nature of reports from the patient and their partner, as well as the fact that PE often overlaps with other sexual dysfunctions, such as ED [9].

It remains controversial whether APE is invariably secondary to an organic disease or may occur as a primary symptom in the absence of an identifiable somatic cause [7]. Future research should focus on identifying more precise biological markers that could help differentiate, diagnose, and classify this dysfunction.

Particular attention should be paid to the relationship between APE and ED. Many studies suggest that PE may, in some cases, function as a compensatory response, where a man makes an unconscious attempt to ejaculate before losing erection [35]. In such cases, addressing ED often improves or normalizes IELT. The treatment of APE should primarily target the underlying cause. Its diverse aetiologies may require interdisciplinary care involving specialists from different medical fields.

Current guidelines recommend treating PE by eliminating or controlling the underlying cause. If the cause cannot be fully eradicated, or if IELT does not improve sufficiently af-

ter causal treatment, pharmacotherapy similar to that used in congenital PE is initiated. It involves the use of SSRIs, dapoxetine in particular, and topical local anaesthetics.

APE raises several important therapeutic questions. One of these concerns the role of dapoxetine: should this on-demand medication be used as a first-line treatment, or should it be considered an adjunct to causal therapy? Given the sudden onset of PE, the rapid and predictable effect of the drug may have a significant positive psychological impact on the patient by reducing the fear of failure. Second, psychotherapy plays a crucial role. It remains important to determine whether behavioural interventions are equally effective for APE and LPE. Patients with APE often experience increased anxiety and frustration. Therefore, psychosexual counselling should be an integral part of treatment, regardless of the underlying cause.

Conclusions

Premature ejaculation is one of the most common male sexual dysfunctions. It can cause substantial psychological and relationship difficulties by impacting many areas of life. Due to its complex and multifactorial aetiology, the disorder requires an interdisciplinary approach. This is particularly important in APE, which arises from an interaction between psychological (e.g. performance anxiety, internal conflicts, and entrenched behavioural patterns) and biological (e.g. serotonergic dysregulation) factors. The common mechanism may involve sympathetic nervous system overactivity and an imbalance between excitation and inhibition.

PE is strongly linked to anxiety and depression. Performance anxiety and excessive monitoring of a partner's reactions may further worsen symptoms, creating a vicious cycle of distress, lower self-esteem, and relationship problems. Differences in diagnostic criteria, including time-based thresholds, highlight the need to standardize diagnostic assessment tools. A thorough clinical interview is essential to identify the cause of PE. This determines the choice of treatment. Regardless of the aetiology, psychotherapy aimed at reducing anxiety and improving both ejaculatory control and communication within the relationship is an important component of care. PE is one of the few curable sexual dysfunctions. Openness and interdisciplinary care are crucial for improving patients' quality of life.

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