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ORIGINAL ARTICLE

The premature ejaculation 'disorder': Questioning the criterion of one minute of penetration☆

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Summary The current trend is to reserve the diagnosis of premature ejaculation (PE) for cases where penetration lasts for about one minute or less. The rationale is that the aetiology is primarily bio-constitutional, and that long-term pharmacological treatment is the only viable option. However, the literature contains little scientific evidence to support this argument. In fact, a good number of individuals who suffer from overly rapid ejaculation present with penetration duration exceeding one minute, and even severe forms of PE have responded favourably to psycho-sexological treatment. Moreover, although certain biological variables are known to influence ejaculation latency time, nothing indicates that they play an exclusive role of psychosocial etiological factors in severe PE. Therefore, it would be 'premature' to base a PE diagnosis on a maximum penetration duration of one minute, which should instead be considered a severity gradient. Given that desired criteria for penetration duration often exceed biological norms, it would be inappropriate to propose that only the most severe forms of PE have constitutional origins. In any case, the constitution is relatively flexible, and can respond to adaptive learning. An adaptive learning approach would undoubtedly be more difficult to apply in severe cases, but not impossible. The issue of whether to use pharmacological versus psycho-sexological treatment could be sidestepped by moving beyond the single criterion of ejaculation latency.

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Qualifying ejaculation 'prematurity': two opposing viewpoints

Everybody, or almost everybody, agrees that premature ejaculation (PE) may be considered a sexual dysfunction if three criteria are met: ejaculation:

- occurs rapidly;
- is felt to be outside the man's control;
- generates a feeling of distress, or at least dissatisfaction.

Beyond this common ground, however, conceptions diverge, mainly concerning the criterion of rapidness (Bonierbale, 2013; Kempeneers et al., in press).

In schematic terms, there are two main opposing viewpoints:

- on the one hand, there is what is known as the ''subjectivist'' view. In its most extreme form, this view proposes the individual's wishes, or subjectivity, as the only relevant referent: an ejaculation is considered premature when it regularly occurs before the man wants it to, and that is all. Rapidness is therefore reduced to lack of control. This viewpoint is well expressed in works by De Carufel (2009) and Metz and McCarthy (2003), among others. In this sense, PE would affect approximately 15 to 30 % of the male population (Laumann et al., 2005; Levinson, 2008; Park et al., 2010; Porst et al., 2007);
- on the other hand, there is the ''objectivist'' view, which seeks to objectively determine ejaculation rapidness in terms of regular occurrence at below a maximum penetration duration. Various authors have proposed various benchmarks, ranging from 15 seconds (WHO, 1994) to seven minutes (Schover et al., 1982). Currently, the trend is to retain a one-minute maximum threshold. In this sense, less than 5 % of the population would be affected (APA, 2013; Jannini et al., 2013; McMahon et al., 2008).

Intrinsic to these two schools of thought are opposing ideal types of normality:

- a purely subjectivist approach would be to regard as normal a man's total voluntary control over his own ejaculation. Pushed to the extreme, this conception becomes a kind of biological utopia;
- a purely objectivist approach would be to judge normality based on statistics alone, with the potentially harmful effect of delegitimising the notion of ''disorder,'' and consequently the therapeutic intention, beyond the pivotal value.

Ejaculation and its timing: observational data

The general population

The first investigation to use objective measures of penetration time in the general population was conducted by Waldinger et al. (2005) in several national samples. The median duration of coitus was 5.4 minutes, with differences across countries ranging from 3.7 minutes in Turkey to 7.6 in the United Kingdom. A second investigation by Waldinger et al. (2009) reported similar results: 4.4 minutes in Turkey, 10 in the United Kingdom, and six for the total sample.

Individual desires

In comparison to the findings of Waldinger et al., a survey conducted by Montorsi (2005) revealed that the respondents estimated normal penetration duration at 13 minutes on average for Americans and 9.6 for Europeans. Elsewhere, Corty and Guardiani (2008) surveyed 34 experienced American and Canadian sexologists and found that what was deemed ''desirable'' duration, that is, from seven to 13 minutes of penetration, exceeded the statistical norm of three to seven minutes, which was considered ''adequate'' duration. This is probably not unconnected to the widespread opinion that achieving an orgasm requires longer tactile stimulation for women than for men: five to 15 minutes on average for women versus four to seven minutes for men (Nagoski, 2010). In short, when it comes to penetration duration, the reference standards clearly exceed the statistical standards. What could — at least in the Western world — be considered a biological norm appears to be rather unsatisfactory from both a hedonic and a sociocultural perspective. There is no shortage of men who would like to delay their ejaculation longer than usual, just as they would like to be a little taller and smarter than the average. Leaving aside the distress stemming from overly rapid ejaculation would being too short or not smart enough count as a 'disorder'? This is not just a biological issue; it is also psychological, sociocultural, and relational (Giami, 2013). Thus, whereas ejaculation can often be delayed by means of chemical or behavioural therapy, psychosexological counselling can provide additional help through training in how to deal with the limitations of one's condition. This summarizes the available treatment options.

PE in men

In a stop-watch study in a sample of 110 men who consulted for PE dysfunction, Waldinger et al. (1998) observed that 90 % of individuals presented a primary (lifelong) and generalised form involving ejaculation within one minute of penetration, with 99 % within two minutes. A regularly cited study by McMahon (2002) in over 1000 Australian men treated for PE produced similar results. However, as this study is included in the scientific database in the form of an abstract for a conference poster presentation, the methodological details remain unknown.

In the wake of these two studies, a group of experts from the International Society for Sexual Medicine (ISSM) proposed reserving the primary and generalised PE diagnosis for individuals presenting ejaculation latency of about one minute or less (McMahon et al., 2008). Voices were raised to persuade the American Psychiatric Association (APA), author of the seminal *Diagnostic and Statistical Manual of Mental disorders*, to integrate this ceiling value into their manual (Segraves, 2010). They were evidently convinced, because the DSM-5, published in May 2013, now makes this distinction (APA, 2013).

Apart from McMahon's study, for which only the abstract is available, the study by Waldinger et al. (1998), based on a one-minute pivotal value, provides little solid corroboration. Some studies even found contradictory results, for instance, two stop-watch studies, one in the United States (Patrick et al., 2005), the other in Europe (Giuliano et al., 2008), each investigating 200 men diagnosed with PE. It appeared that over 40% of ejaculations, although reported as premature, actually occurred two minutes after penetration. Nevertheless, it is notable that, unlike the study by Waldinger et al., these two studies did not exclusively address primary and generalised forms of PE.

If we can agree with Althof et al. (1995), Pryor et al. (2006), and Rosen et al. (2007) that the self-estimates reported by men suffering from PE reflect actual penetration duration, we must also cite two recent studies that contradict the observations of Waldinger et al. One investigation by McMahon et al. (2012) in the Asia-Pacific region showed that, of 816 men diagnosed with PE based on the premature ejaculation diagnostic tool (Symonds et al., 2007), 74% reported ejaculation latencies exceeding two minutes, and almost 90% reported latencies exceeding one minute. In a study conducted in Belgium by Kempeneers et al. (2013), 26% of 341 subjects with primary and generalised PE diagnosis (DSM-IV-TR criteria) reported penetration durations exceeding two minutes, and about 50% reported durations exceeding one minute.

Determination of the problem and the treatment

In the domains of mind and behaviour, the concepts of 'health' and 'disorder' are defined as much in social as biological terms, and the rationale for a treatment is intimately related to the conception of the problem.

When adequate training and proper sexual education are offered as 'treatments' to individuals with complaints of rapid ejaculation — an estimated 15 to 30% of the population — this does not pose ethical problems. Economic problems, maybe, but not so much ethical, and less ethically disturbing than if, for example, training and remedial courses were offered to individuals suffering from not feeling as intelligent as they would like. Although there remains the larger issue of the legitimacy of social normalisation, these types of 'soft' treatments are perceived as not really liable to harm the beneficiaries. Thus, they provide a reasonably good fit with a broad conception of a 'problem' that a good number of individuals experience, a conception based essentially on individual suffering.

It is quite another story when we consider pharmacological treatments and their trail of medium- and long-term side effects. Here, behavioural and mental normalisation can entail biological costs for individual users, costs that must be weighed against the expected benefits. Today we hear regular denouncements of the large-scale use of psychotropics — which include active agents used to treat PE — due to the associated biological costs, which represent a heavy price to pay for the ''cult of performance'' (Ehrenberg, 1998; Frances, 2013). It would therefore appear preferable to limit these treatments, and consequently the diagnosis, to cases that are untreatable by the 'softer' methods. In this perspective, a potentially toxic treatment should target only the part of the problem — the 'real' problem — that is attributable to a biological abnormality, to the exclusion of problems with psychosocial causes. Accordingly, the recognition of an essentially biological problem would indicate the therapeutic use of doping agents.

Should primary severe PE be considered a neurobiological disorder? Why? How? With what limitations?

How did the ISSM and the APA end up determining a maximum threshold of one minute of penetration as the diagnostic criterion for PE, based on such paltry scientific evidence? It is hard not to hypothesise that this consistent view was adopted in order to justify a pharmaceutical approach to the problem.

From a pharmaceutical industry perspective, the establishment of a ceiling duration would certainly have the disadvantage of delegitimising therapeutic intervention beyond the pivotal value (Waldinger, 2008), but it would also have the advantage of justifying pharmaceutical intervention within this limitation, and even more so if the form of PE is defined as a biological abnormality, and if pharmacological treatment is designated as the sole option for improving the situation. This is precisely the view defended by the ISSM's expert group. Should we consider this a mere coincidence? Most of the experts are aware of the profits to be gained by the pharmaceutical industry.

However, the choice to relate primary PE (characterised by ejaculation latency of less than one minute) to a neurobiological dysfunction is based on a syllogism. Epidemiological studies cited by the group of experts indicate that many bodily diseases (e.g., osteoporosis, diabetes, and cardiovascular diseases) affect approximately 0.5 to 2.5% of the population. In so far as the threshold value of one minute of penetration reduces the proportion of men concerned to about the same number (< 5%, see above), the severe form of PE becomes theoretically equivalent to a bodily deficiency (McMahon et al., 2008).

This syllogistic logic does not by itself prove that the conclusion is wrong. Evoking other arguments to support their proposal, the authors cite a series of studies that point to the contribution of bioconstitutional factors to PE. They refer to Jern et al. (2007), who assessed heritability rates of PE, all types combined, at 28% in a series of Finnish twins; to Corona et al. (2011), who suggested a potential impact of the hormonal environment; and to Janssen et al. (2009), who, in a sample of PE subjects presenting penetration durations of less than one minute, noted that carriers of the LL variant of the *5-HTTLPR* gene involved in serotonin transportation were characterised by even shorter ejaculation latencies than counterpart carriers of the SS and SL variants. However, nothing in these studies, or in any other studies to our knowledge, allows concluding that these biological factors play an exclusive or even a leading role in primary PE with ejaculation latencies of less than one minute. The reduction of this clearly severe form of the problem to a neurochemical imbalance remains completely hypothetical at this point.

Consistent with the perception of severe primary PE attributable to a bioconstitutional deficiency, the long-term use of serotonergic agents to delay the ejaculation reflex has often been presented as the only viable treatment (Althof et al., 2010; Porst, 2012; Waldinger, 2007). Yet at least three clinical trials appear to have refuted this proposal. Thus, De Carufel and Trudel (2006), De Sutter et al. (2002), and Kempeneers et al. (2012) found that subjects affected by particularly short ejaculation latency may also respond favourably to sexual behavioural therapy. It is true they showed less improvement in comparison to PE subjects with penetration duration exceeding one minute (Kempeneers et al., 2012), but there were improvements nonetheless. Similar findings were obtained for medication treatments (Waldinger, 2007), such that at the end of the day, latencies shorter than one minute represent a severity gradient of the disorder that limits, not to say eradicates, the effectiveness of any treatment whatsoever.

By way of a conclusion

In the last 10 to 15 years, many studies have been published to clarify and highlight the biological tenets of PE. Although the knowledge has been advanced, much remains to be explained (Bonierbale, 2013). In the wake of this progress, a good number of clinical trials of pharmacological treatments for this problem have been carried out, particularly on selective serotonin reuptake inhibitors (SSRIs). In comparison, the volume of publications on psychological and sociocultural aspects is insignificant, with clinical trials of sexual behavioural approaches accounting for barely 1000 subjects, sometimes contradictory findings, and methods that are uncertain and often difficult to compare between studies (Berner and Gunzler, 2012; Jern, 2013; Kempeneers et al., in press; Melnik et al., 2011). This disproportion of available information, which has arguably been commercially influenced, has contributed to draw public and clinical attention to biological and chemotherapeutic components of the problem, to the detriment of psychosocial and sex therapy components. This has no doubt fostered the perception that PE is reduced to a bodily deficiency.

The state of the knowledge does not allow concluding that severe forms of primary PE stem from a neurobiological problem that can be treated by medications alone. While fully supporting the presence of bioconstitutional factors liable to increase the risk for PE and its severity, we must also recognise the enormous plasticity of the biological condition. In terms of penetration time, the biological norms are in any case below sociocultural norms, such that legions of 'biologically normal' men must learn how to control their excitement in order to prolong coitus beyond their natural limit. And many manage to do so, with or without the help of a sex therapist. The logic is not different for men who present *a priori* penetration times of less than one minute. It could be more difficult for these men to learn new behaviours, but not impossible.

Two therapeutic strategies are available: use chemical agents to act on nerve transporters, or apply behavioural therapy to achieve better control of sexual excitement. It appears that the decision to use either of these strategies cannot be based on *a priori* penetration duration. In addition, they can be viewed as fully complementary (Kempeneers et al., in press).

Strictly speaking, due to the potential side effects, a medication strategy should not be proposed as the first-line treatment, and probably even not for men presenting ejaculatory latency times of less than one minute. In time, the development of effective self-treatment instruments should make sexual therapy more accessible as a first-line treatment (De Sutter et al., 2002; Kempeneers et al., 2012; Kempeneers et al., in press). Moreover, once their use has been clarified, and because the aim is to relieve suffering, it would be unfortunate if medication treatments were prohibited when psychosexological treatment proves to be ineffective or impossible, even when dealing with penetration times considered statistically normal. Finally, it could be beneficial to combine the two treatment types, particularly for severe forms of PE that are resistant to either approach separately. Although their synergistic effects have been established (Li et al., 2006; Yuan et al., 2008), they remain underexplored.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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