Premature or Delayed Ejaculation

Understanding Ejaculatory Timing, Causes, Diagnosis, Behavioral Control Techniques and Integrative Treatment

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Introduction

In my clinical practice, men often come to me worried about one of two apparently opposite problems.

One patient says:

“Doctor, I ejaculate before I want to. Sometimes it happens before penetration or immediately afterwards.”

Another patient tells me:

“Doctor, my erection is fine and I remain sexually active for a long time, but ejaculation either takes extremely long or does not happen at all.”

The first problem may represent **premature ejaculation**, also called early ejaculation. The second may represent **delayed ejaculation**.

Although these conditions occur at opposite ends of the ejaculatory-timing spectrum, they share something important: both can affect confidence, sexual satisfaction, relationships, fertility planning and emotional well-being.

Modern sexual medicine therefore does not judge ejaculatory health simply by counting minutes. The most important questions are whether ejaculation occurs in a way that is persistently different from what the person wants, whether control is impaired, whether the change is consistent, and whether it causes significant distress.

The European Association of Urology's **2026 Sexual and Reproductive Health Guidelines**, which incorporated updated evidence specifically for disorders of ejaculation, describe ejaculation as a complex process involving neurological,

hormonal and anatomical pathways. The same guidance emphasizes that premature and delayed ejaculation require individualized assessment rather than a one-treatment-for-all approach.

I often tell my patients:

The purpose of treatment is not to make intercourse last for a particular number of minutes. The purpose is to restore reasonable control, comfort, satisfaction and confidence.

Understanding Normal Ejaculation

Ejaculation is not simply semen suddenly leaving the penis.

It is a coordinated neurological and muscular process involving the brain, spinal cord, autonomic nervous system, prostate, seminal vesicles, vas deferens, urethra, pelvic-floor muscles and sensory nerves.

Sexual desire and stimulation first produce arousal. With increasing stimulation, the nervous system reaches an ejaculatory threshold. Seminal fluid then moves into the urethra during the **emission phase**, followed by rhythmic muscular contractions that expel semen during the **expulsion phase**.

Orgasm and ejaculation commonly occur together, but medically they are not exactly the same process. A man can occasionally experience orgasm with little or no semen, and neurological or surgical conditions can alter ejaculation even when orgasmic sensation remains.

The 2026 EAU guidance emphasizes this neurological, hormonal and anatomical complexity, which explains why ejaculatory disorders can have psychological, medication-related, endocrine, neurological, inflammatory and sexual causes.

What Is Premature Ejaculation?

Premature ejaculation, or **PE**, does not simply mean ejaculating “quickly.”

Three factors are particularly important:

ejaculation occurs earlier than desired, control over ejaculation is consistently poor, and the problem causes distress or relationship difficulty.

The International Society for Sexual Medicine's evidence-based definition describes lifelong PE as ejaculation occurring before or within about one minute of vaginal penetration from the earliest sexual experiences, together with difficulty delaying ejaculation and negative consequences such as frustration, distress or avoidance of

intimacy. Acquired PE involves a bothersome reduction from a man's previous ejaculation time, often to approximately three minutes or less, together with impaired control and distress.

These timing figures are useful for research and diagnosis, but they should not become a source of obsession for patients.

A man does **not** need to keep a stopwatch beside his bed.

The current EAU guideline specifically states that ejaculation time alone is insufficient for diagnosing PE and that perceived control, distress and interpersonal consequences must also be considered.

Lifelong Premature Ejaculation

In lifelong PE, early ejaculation has generally been present since a man's first sexual experiences.

The man may report:

“I have never really been able to control ejaculation.”

Even with different partners or circumstances, the problem may remain relatively consistent.

Lifelong PE is believed to involve complex biological mechanisms, including central and peripheral neurotransmitter pathways and possibly genetic or neurobiological susceptibility. It should therefore not automatically be blamed on anxiety, masturbation or lack of sexual experience.

This distinction is important because telling a lifelong PE patient simply to “relax” may be inadequate.

Acquired Premature Ejaculation

Acquired PE is different.

The patient may tell me:

“Doctor, I previously had good control. This problem started only recently.”

That change deserves attention.

Current EAU guidance identifies several possible contributors to acquired PE, including performance anxiety, psychological or relationship difficulties, erectile dysfunction,

prostatitis, hyperthyroidism and poor sleep quality. Other metabolic and general-health associations have also been reported.

In such patients, treating the cause may be more important than immediately prescribing a delay medicine.

For example, if a man rushes intercourse because he fears losing his erection, the underlying problem may actually be erectile dysfunction.

Variable Premature Ejaculation

Not every episode of early ejaculation is a disorder.

A man may occasionally ejaculate rapidly because he is highly excited, has not had sexual activity for some time, is with a new partner, is anxious or is simply experiencing normal variation.

The EAU classifies **variable PE** as inconsistent and irregular episodes of early ejaculation that can represent normal variation in sexual function.

This is particularly important because many healthy men unnecessarily believe they are diseased after one or two rapid sexual encounters.

Subjective Premature Ejaculation

Another group of men believes that ejaculation is excessively rapid even though their actual ejaculation time falls within a normal range.

They may compare themselves with pornography, social-media claims, friends or exaggerated advertisements promising intercourse lasting for an hour.

The EAU describes this as **subjective PE**, in which a person perceives ejaculation as abnormally rapid despite a normal or even relatively long latency. It should not automatically be interpreted as true medical pathology.

In these patients, education and realistic expectations may be more important than medication.

How Common Is Premature Ejaculation?

Reported prevalence varies enormously because studies have used very different definitions.

Older surveys using a simple question such as “Do you ejaculate too early?” reported rates approaching 20–30% or even higher. When stricter diagnostic definitions are used, however, rates of true lifelong and acquired PE are substantially lower. Two large observational surveys cited by the EAU reported lifelong PE rates of approximately 2–3% and acquired PE around 4%, while many additional men reported variable or subjective forms.

Therefore, statements such as “one-third of all men have a medical disorder” can be misleading.

Occasional early ejaculation is common.

Persistent PE meeting diagnostic criteria is a more specific condition.

What Is Delayed Ejaculation?

Delayed ejaculation, or **DE**, is almost the opposite problem.

A man has adequate sexual stimulation but experiences a marked delay in ejaculation, ejaculates only occasionally, or cannot ejaculate during partnered sexual activity.

Importantly, simply being able to have intercourse for a long time does not mean a man has delayed ejaculation.

Some men naturally take longer and are perfectly satisfied.

The condition becomes clinically significant when the delay is **unwanted, persistent and distressing**.

The diagnostic framework referenced by the EAU considers marked delay, infrequency or absence of ejaculation on most sexual occasions, persisting for at least six months and causing distress.

Delayed Ejaculation Versus Anejaculation

These terms should not be confused.

With **delayed ejaculation**, ejaculation eventually occurs but requires prolonged or unusually intense stimulation.

With **anejaculation**, semen does not come out at all.

Another condition, **retrograde ejaculation**, occurs when semen travels backward into the bladder instead of exiting normally through the penis.

These disorders can look similar to patients but require different investigations and treatments.

A man saying:

“Nothing comes out”

therefore needs more detailed evaluation than simply being labelled as having delayed ejaculation.

Lifelong and Acquired Delayed Ejaculation

Like PE, delayed ejaculation may be lifelong or acquired.

A patient with lifelong DE might say:

“I have always struggled to ejaculate during intercourse.”

Someone with acquired DE may say:

“I was completely normal previously, but during the last year ejaculation has become very difficult.”

This second history immediately makes me think about what changed.

Did the patient begin an antidepressant?

Has diabetes progressed?

Was there prostate or pelvic surgery?

Did sexual desire change?

Is erectile function poorer?

Did significant relationship stress begin?

Is there a neurological problem?

The current EAU guideline identifies medical, medication-related, neurological, endocrine, inflammatory and psychological contributors to delayed ejaculation.

Causes of Premature Ejaculation

Patients frequently ask:

“Doctor, what exactly is causing this?”

There is rarely one universal answer.

In lifelong PE, biological susceptibility may play an important role. Researchers have investigated serotonin signaling, central and peripheral nervous-system factors, genetic influences, hormonal pathways and penile sensitivity.

In acquired PE, the possible causes are often easier to identify.

Performance anxiety is common. The man becomes extremely focused on ejaculation and repeatedly thinks:

“I must not finish.”

That monitoring can paradoxically increase tension and make control more difficult.

Relationship conflict can contribute.

Erectile dysfunction can contribute when a patient rushes penetration because he fears losing his erection.

Poor sleep, psychological stress, hyperthyroidism, prostatitis and certain metabolic conditions may also be associated with acquired PE.

The important lesson is that **PE is not automatically caused by masturbation, semen weakness or lack of masculinity**.

Erectile Dysfunction and Premature Ejaculation

This combination is extremely important clinically.

A man tells me:

“Doctor, I ejaculate too quickly.”

But when I ask more questions, I discover that he is also struggling to maintain an erection.

Because he fears that the erection will disappear, he increases stimulation rapidly and rushes intercourse.

Ejaculation then occurs early.

If I treat only PE, I may miss the actual problem.

The 2026 EAU guideline therefore recommends treating erectile dysfunction and other relevant sexual or genitourinary conditions before or alongside PE management.

Psychological Factors and PE

Anxiety can be either a cause or a consequence.

A man may originally experience PE because of heightened arousal.

He becomes embarrassed.

Before the next sexual encounter, he worries.

That anxiety increases muscular tension and attention to ejaculation.

PE happens again.

A cycle develops:

early ejaculation → embarrassment → performance anxiety → increased monitoring → another episode of early ejaculation.

Breaking this cycle may require behavioural training, education, relationship communication and sometimes psychological treatment alongside medical therapy.

Causes of Delayed Ejaculation

Delayed ejaculation usually requires a different clinical mindset.

Where PE can involve excessive speed through the arousal cycle, DE may involve insufficient effective stimulation, altered sensation, medication effects, neurological problems or an inability to progress naturally toward orgasm.

The EAU identifies possible contributors including diabetic autonomic neuropathy, multiple sclerosis, spinal cord injury, pelvic or prostate surgery, urethral or prostate inflammation, hypothyroidism, prolactin disorders, antidepressants, antipsychotics, some antihypertensive medicines, alpha-blockers, alcohol and psychological or relationship distress.

A patient's medicine list is therefore extremely important.

Antidepressants and Delayed Ejaculation

Selective serotonin reuptake inhibitors, or SSRIs, are well known to delay ejaculation in some men.

Interestingly, the same effect is deliberately used therapeutically in premature ejaculation.

But in another patient, the ejaculation delay becomes excessive and unwanted.

This demonstrates why treatment must be individualized.

A medicine that can help PE may worsen DE.

Patients should **not abruptly stop an antidepressant** because of sexual side effects. Sudden discontinuation can produce withdrawal symptoms and may worsen the psychiatric illness for which the medicine was prescribed.

Instead, the prescribing physician and sexual-health clinician should review the problem together.

Diabetes and Neurological Disease

Normal ejaculation depends on intact nerve pathways.

Long-standing diabetes can damage autonomic nerves.

Spinal-cord injury, multiple sclerosis and some pelvic operations can also interfere with emission or ejaculation.

In these situations, simply teaching behavioural sexual techniques may not be sufficient.

Medical evaluation becomes essential.

Is Low Testosterone the Main Cause of Delayed Ejaculation?

Patients frequently assume that every male sexual complaint is caused by low testosterone.

The evidence is more complicated.

The EAU notes that although testosterone deficiency has historically been proposed as a contributor to delayed ejaculation, more contemporary studies have not consistently shown a direct relationship between serum testosterone and ejaculation time.

Testosterone should therefore be assessed when clinically indicated rather than prescribed automatically for delayed ejaculation.

This is particularly important for men seeking fertility, because external testosterone can suppress sperm production.

Masturbation Patterns and Delayed Ejaculation

Some patients can ejaculate easily during masturbation but find ejaculation extremely difficult with a partner.

This pattern is clinically useful.

It demonstrates that the ejaculatory system is physically capable of functioning.

In selected men, a highly specific pattern of pressure, speed, grip, posture or stimulation during masturbation may become difficult to reproduce during partnered sex.

The EAU lists masturbation style and mismatch between arousal patterns and partnered sexual stimulation among proposed psychosexual contributors to delayed ejaculation.

This should not be turned into moral judgment about masturbation.

The relevant question is whether a very specific stimulation pattern appears to be contributing to the patient's difficulty.

The Difference Between Ejaculatory Control and "Holding Semen"

I often encounter another misunderstanding.

Some patients believe that the objective of treatment is to "hold semen inside" for as long as possible.

That is not the medical objective.

Normal ejaculation is a physiological process.

With PE, we are trying to improve control and reduce distress.

With DE, we are trying to restore the ability to progress toward ejaculation when the person wants it.

The goal is therefore **appropriate control rather than indefinite suppression**.

How Premature and Delayed Ejaculation Affect Relationships

Both conditions can create misunderstanding.

With PE, the partner may think:

"He is only interested in finishing quickly."

The man may actually feel deeply embarrassed.

With DE, the partner may think:

"He is not attracted to me."

The man may actually be exhausted and frustrated because he cannot reach ejaculation despite strong attraction.

Without communication, both partners make interpretations that may be wrong.

The EAU reports that PE can reduce sexual satisfaction and confidence, strain relationships and contribute to anxiety, embarrassment and emotional distress. DE is also associated with poorer sexual satisfaction, greater distress and higher rates of anxiety or depression in affected groups.

This is why I frequently involve the partner, with the patient's permission, when relationship dynamics are important.

Ejaculation and Fertility

Ejaculatory disorders can sometimes affect fertility, but the relationship needs to be explained carefully.

A man with premature ejaculation is **not automatically infertile**.

If semen is deposited adequately in the vagina and sperm parameters are normal, early ejaculation by itself may not prevent conception.

However, if ejaculation repeatedly occurs before penetration and semen cannot be deposited intravaginally during the fertile window, conception can become difficult.

Delayed ejaculation can create a different problem. If a man is unable to ejaculate during intercourse, natural semen deposition may not occur even when sperm production is otherwise normal.

Anejaculation and retrograde ejaculation can have an even more direct effect on fertility.

When ordinary ejaculation cannot provide sperm for conception, specialist methods such as penile vibratory stimulation, electroejaculation or surgical sperm retrieval may be considered in selected cases. Male infertility guidance also recognizes induced ejaculation and sperm-retrieval techniques for men with aspermia or other ejaculatory dysfunctions.

A Special Point for Men Trying to Conceive

Treatment choices for PE deserve additional attention when a couple is actively trying for pregnancy.

The current EAU guidance notes concerns about potential adverse effects of some SSRIs on sperm parameters and advises that men trying to conceive should avoid these PE medications. It also cautions that topical lidocaine/prilocaine products may adversely affect sperm cells and should not be used by couples seeking parenthood.

This does not mean that every exposure causes infertility.

It means fertility goals should be discussed **before** selecting treatment.

As a physician focused on sexual disorders and infertility, I consider this particularly important.

The same medicine cannot be chosen for a 25-year-old couple actively trying for pregnancy and a patient with no fertility plans without considering those circumstances.

How I Evaluate Premature Ejaculation

Diagnosis begins with conversation, not laboratory tests.

I want to know whether PE has existed since the earliest sexual experiences or began after a period of normal control.

I ask whether it happens almost every time or only occasionally.

I ask whether it occurs with every partner or only under particular circumstances.

I assess erection quality.

I ask about urinary or prostate symptoms.

I ask about sleep, stress, relationship concerns and medication use.

I want to know whether ejaculation occurs before penetration, immediately after penetration or somewhat later.

Most importantly, I ask:

“How much control do you feel you have?”

and

“How much does this problem actually bother you?”

Current EAU recommendations similarly emphasize medical and sexual history, self-estimated ejaculation latency, perceived control, distress and interpersonal consequences. Laboratory testing should be guided by clinical findings rather than performed routinely in every patient.

How I Evaluate Delayed Ejaculation

With DE, the history is somewhat different.

I want to know whether ejaculation is delayed during intercourse only or during masturbation as well.

Can the patient reach orgasm?

Does semen appear?

How long has the problem existed?

Is it lifelong or newly acquired?

Did it begin after a medicine was started?

Has the patient had prostate, abdominal or pelvic surgery?

Is sensation reduced?

Does he have diabetes or neurological disease?

Is sexual desire normal?

Is pornography or highly specific stimulation involved?

Is erection adequate?

How does the partner experience the problem?

The EAU recommends a detailed medical, sexual and physical assessment of men with DE, including ejaculation, sensation, stimulation patterns, cultural context, desire, arousal, orgasm, medications, relationship satisfaction and the partner's perspective.

When Laboratory Tests Are Needed

There is no single “ejaculation test.”

Investigations should be guided by the clinical story.

In acquired PE, a patient with symptoms of thyroid disease may require thyroid evaluation.

A man with erectile dysfunction may require assessment for diabetes, cardiovascular risk or hormone disorders.

A DE patient with symptoms suggesting endocrine disease may need appropriate hormonal testing.

Men with infertility may require semen analysis and reproductive evaluation.

A man with suspected retrograde ejaculation may need examination of post-ejaculatory urine.

The doctor should investigate the **cause**, rather than ordering every possible test for every patient.

Behavioral Control Techniques for Premature Ejaculation

Behavioral treatment remains one of the subjects patients ask me about most frequently.

The first point I explain is that these techniques are **training methods rather than instant cures**.

The latest EAU guideline considers psychosexual approaches—including behavioural, cognitive and couple-based methods—potentially useful, particularly in combination with pharmacological treatment. Evidence for behavioural therapy alone remains less consistent than evidence for established PE medications.

A systematic review of randomized studies similarly found mixed results for behavioural therapy alone, while combinations of behavioural and medical treatment sometimes improved ejaculatory control, sexual satisfaction and anxiety more than medication alone.

Learning the Arousal Curve

Before practicing any technique, I teach patients to recognize their sexual-arousal level.

Imagine arousal on a scale from **0 to 10**.

At zero, there is no meaningful sexual stimulation.

As arousal rises through the middle range, ejaculation is still controllable.

At a very high level, the nervous system approaches the point at which ejaculation becomes difficult or impossible to stop.

Men with PE often recognize the point of no return too late.

The purpose of behavioural training is therefore not simply to “stop ejaculation.”

It is to learn:

What does my body feel like before I lose control?

Recognizing this earlier gives the patient time to reduce stimulation.

The Stop–Start Technique

One of the best-known behavioural approaches is the **stop–start technique**.

The principle is simple.

Sexual stimulation continues until the man notices that he is approaching a high level of arousal—but before ejaculation becomes inevitable.

Stimulation then stops.

The patient allows arousal to decrease.

Once the sensation of imminent ejaculation settles, stimulation begins again.

This process can be repeated several times during practice.

The objective is not to frustrate the patient.

It is to teach him to identify and regulate the transition between moderate arousal and the ejaculatory threshold.

The stop–start method has been included in behavioural PE studies for many years. A randomized controlled study of vibrator-assisted stop–start training also reported improvement in PE symptoms, while additional psychoeducation and mindfulness appeared to improve associated distress and anxiety.

The technique can initially be practiced individually and later incorporated into consensual partnered activity if both partners are comfortable.

The Squeeze Technique

Another classical approach is the **squeeze technique**.

Like stop–start, stimulation is paused as ejaculation becomes close. Traditionally, gentle pressure is then applied to the penis for a brief period until the urge decreases before stimulation resumes.

I do not advise aggressive squeezing.

There should be no significant pain, bruising or injury.

For many patients, the stop–start technique is simpler because it does not require compression.

Current evidence does not clearly establish that squeezing is superior to stopping stimulation alone. Reviews of psychobehavioural approaches suggest that pause-based stimulation training may be useful, while the added value of specific squeeze variations remains uncertain.

Slow the Escalation of Arousal

Some men with PE unknowingly move from minimal stimulation to maximal intensity very quickly.

They may rush penetration.

They may hold their breath.

They may tighten the abdomen, buttocks and pelvic floor.

They may move faster as soon as they become excited.

This creates a rapid rise in arousal.

I teach these patients to notice the escalation rather than constantly fighting ejaculation at the last second.

Slowing stimulation when arousal first rises is usually easier than trying to stop ejaculation once the reflex has already become inevitable.

Breathing and Relaxation

Many anxious patients unconsciously hold their breath during sex.

Their shoulders rise.

The abdomen becomes rigid.

Pelvic muscles tighten.

Their attention becomes fixed entirely on ejaculation.

Slow breathing and deliberate relaxation can help reduce this pattern.

The purpose is not to perform a complicated meditation during intercourse.

It is simply to remain aware of the body rather than entering panic.

Current EAU guidance notes potential benefit from combining psychoeducation, start–stop exercises and mindfulness techniques, particularly for symptoms and PE-related distress.

Mindfulness and PE

Mindfulness in sexual therapy means paying attention to present sensations without continuously evaluating performance.

A patient with PE often thinks:

“How long has it been?”

“Am I about to finish?”

“Will my partner be disappointed?”

This turns intimacy into an examination.

Mindfulness aims to shift attention from judgment to awareness:

What sensations are present?

How quickly is arousal rising?

Is the body tense?

Can stimulation be slowed before the point of inevitability?

It should be regarded as an adjunct rather than a proven stand-alone cure.

Pelvic-Floor Awareness

Pelvic-floor muscles participate in erection and ejaculation.

Because of this, pelvic-floor exercises are sometimes recommended for PE.

Some studies report benefit, while overall evidence is still less established than for standard pharmacological treatment. Reviews have not consistently shown that simply strengthening pelvic muscles is uniquely effective for PE.

I therefore emphasize **awareness and control**, not simply performing hundreds of contractions.

A patient who is already excessively tightening the pelvic floor during sexual activity may actually need to learn relaxation and coordination.

Pelvic-floor physiotherapy can be helpful when dysfunction is suspected.

Sensate-Focus Principles

Another useful concept from sex therapy is **sensate focus**.

The couple temporarily reduces emphasis on penetration, ejaculation and orgasm and instead pays attention to comfortable physical sensation and affectionate touch.

This can help when intercourse has become a performance test.

For example, a PE patient may think:

“Every sexual encounter proves whether I succeeded or failed.”

Removing that immediate test can reduce anticipatory anxiety and help rebuild confidence.

Behavioral research on PE has included sensate-focus techniques, although overall evidence remains variable.

Partner Involvement

Premature ejaculation is often easier to manage when the partner understands the treatment.

The partner can help slow stimulation when the man signals increasing arousal.

They can avoid criticizing or measuring every encounter.

They can treat practice sessions as training rather than tests.

The 2026 EAU recommendations specifically advise assessing the impact of PE on the partner and incorporating couple-based approaches where appropriate.

Good communication can sometimes reduce more anxiety than another attempt at “lasting longer.”

Behavioral Strategies for Delayed Ejaculation Are Different

One of the most important clinical mistakes is giving the same behavioural advice to PE and DE patients.

The goals are opposite.

In PE, we often try to prevent arousal from rising too quickly.

In DE, we may need to improve effective arousal and remove barriers preventing progression toward orgasm and ejaculation.

The current EAU guideline describes psychological approaches for DE that may include sexual education, increasing appropriate genital stimulation, reducing performance

anxiety, retraining masturbation practices and addressing a mismatch between the stimulation that produces arousal alone and what occurs with a partner.

Increase Effective Stimulation in Delayed Ejaculation

A DE patient sometimes spends a very long time having intercourse while arousal actually decreases.

He becomes tired.

His partner becomes uncomfortable.

Both become frustrated.

More time is not necessarily the solution.

The question should be:

What type of stimulation actually moves this patient toward orgasm?

In some patients, changing the intensity, rhythm or form of stimulation may be more useful than continuing intercourse for another hour.

The aim is not extreme stimulation.

It is identifying effective, comfortable stimulation.

Retraining a Very Specific Masturbation Pattern

Suppose a man can ejaculate only when masturbating with a very specific grip, pressure, posture or speed that cannot realistically occur during partnered intimacy.

A therapist may gradually help him broaden his arousal pattern.

This can involve changing pressure or technique gradually and incorporating more partner-compatible stimulation over time.

The idea is not:

“Masturbation is bad.”

The idea is:

“Your nervous system may have become accustomed to one very specific stimulation pattern; can we broaden it?”

The EAU includes retraining of masturbation practices among the psychosexual approaches that may be considered in DE.

Reducing Performance Pressure in Delayed Ejaculation

A DE patient may begin each sexual encounter thinking:

“Tonight I absolutely must ejaculate.”

His partner waits.

Minutes pass.

Both become increasingly aware of the problem.

The patient tries harder.

Arousal falls.

The more he attempts to force orgasm, the further away it feels.

Psychosexual therapy can help move attention from **performance pressure to pleasurable stimulation**.

The goal is not to “try harder.”

Sometimes the goal is to stop treating ejaculation as an examination.

Fantasy, Arousal and Context in DE

In selected DE patients, the stimulation that produces strong arousal during solitary activity may be very different from partnered sexual activity.

The EAU notes that psychosexual management can include recalibrating mismatches between fantasy-based arousal and real-life sexual situations.

This should be discussed without judgment.

The goal is not to police a patient's thoughts.

It is to understand how their arousal system works.

Sex Therapy for Delayed Ejaculation

Evidence for DE treatment remains much more limited than for PE.

The EAU states that the psychological-treatment literature is scarce, but referral to a qualified sexual therapist, psychologist or psychiatrist is often appropriate when psychological or relational factors are prominent.

A 2024 randomized study of men with primary intravaginal anejaculation found better outcomes when sexual therapy was combined with a particular physical stimulation intervention than with either approach alone. The study is encouraging but represents a specific patient group and does not establish one universal treatment for all DE.

Medical Treatment of Premature Ejaculation

Behavioral training is valuable, but established medical treatment is often required, especially in lifelong PE.

According to the 2026 EAU guideline, on-demand **dapoxetine** and a metered **lidocaine/prilocaine topical spray** are established first-line options for lifelong PE in jurisdictions where they are approved and available. Daily SSRIs and clomipramine are commonly used alternatives, often off-label depending on the country.

These treatments should be prescribed after assessment.

They are not appropriate for everyone.

Medical history, other medicines, blood pressure, fertility plans, psychiatric history and potential adverse effects matter.

Dapoxetine

Dapoxetine is a short-acting SSRI designed for on-demand treatment of PE and is approved in a number of countries, although availability and regulatory status differ internationally.

Studies reviewed by the EAU show improvements in ejaculation latency, perceived control, distress and satisfaction. Common adverse effects include nausea, headache, dizziness and gastrointestinal symptoms, and occasional fainting-related reactions have been reported.

This is why it should not be treated as an ordinary over-the-counter performance tablet.

Daily SSRIs and Clomipramine

Longer-acting SSRIs such as paroxetine, sertraline and fluoxetine can delay ejaculation.

However, they were originally developed as antidepressants and are typically used off-label for PE.

Possible adverse effects include fatigue, nausea, reduced libido, erection difficulty and excessively delayed or absent ejaculation. They should not be started or stopped casually.

In other words, a drug intended to correct premature ejaculation can sometimes push ejaculation too far in the opposite direction.

Careful dose and treatment selection matter.

Topical Anaesthetic Treatment

Lidocaine/prilocaine preparations reduce penile sensitivity and can delay ejaculation.

They can be effective, but excessive numbness is not the goal.

Product can sometimes transfer to the partner and cause genital numbness unless appropriate precautions are followed.

As noted earlier, fertility considerations also matter because the EAU advises against certain lidocaine/prilocaine products when a couple is actively trying to conceive.

Why I Am Cautious About Tramadol

Tramadol can delay ejaculation, but it is an opioid analgesic.

The EAU considers it a possible later-line treatment while emphasizing concerns about long-term safety and addiction potential.

I do not regard a potentially dependence-forming pain medicine as something patients should casually purchase for sexual performance.

It requires careful medical judgment.

Surgery for Premature Ejaculation

Patients occasionally ask about injections or nerve surgery advertised as permanent PE solutions.

The latest EAU guideline advises caution with glans hyaluronic-acid injection because more safety information is needed and specifically advises against dorsal neurectomy because of concerns about irreversible effects and insufficient safety data.

A permanent intervention should never be undertaken lightly for a condition that often has safer treatment options.

Medical Treatment of Delayed Ejaculation

Delayed ejaculation is more difficult pharmacologically.

The major difference from PE is that **there is currently no FDA- or EMA-approved medication specifically for delayed ejaculation**.

Various drugs—including bupropion, cabergoline, buspirone and several adrenergic agents—have been tried in selected circumstances, but evidence is limited and high-quality randomized trials are lacking. The EAU therefore states that no one medication has proven definitive efficacy or superiority for DE.

This is an area where internet self-treatment can be particularly problematic.

A medication that influences dopamine, blood pressure or hormones should not be taken simply because somebody online claimed that it improves ejaculation.

The First Medical Step in Acquired Delayed Ejaculation

If DE started after a medication was introduced, I first examine the medication history.

If it started after surgery, the surgical history matters.

If the patient has diabetes, neurological examination may be relevant.

If he has reduced sexual desire, we investigate that.

If he can ejaculate during masturbation but not with his partner, psychosexual factors become especially important.

This is more logical than immediately prescribing another medicine to counteract the first medicine.

Penile Vibratory Stimulation and Selected Neurological Cases

Penile vibratory stimulation is used in selected men with neurological ejaculatory dysfunction or anejaculation.

In spinal-cord injury, for example, stimulation may help activate the ejaculation reflex when relevant neural pathways remain intact.

Where fertility is desired and ordinary ejaculation cannot be achieved, specialist reproductive options may include vibratory stimulation, electroejaculation or surgical sperm retrieval.

These are specialist procedures, not home remedies.

Lifestyle and Ejaculatory Health

Patients often ask whether food, exercise or sleep can correct ejaculation timing.

Lifestyle does not replace specific treatment, particularly in lifelong PE or neurological DE.

However, general health matters.

Poor sleep is associated with acquired PE in current guideline evidence.

Diabetes and metabolic illness may damage the neurological and vascular systems involved in sexual function.

Stress and depression may worsen performance anxiety.

Excessive alcohol can interfere with arousal and ejaculation.

Regular physical activity, sufficient sleep, appropriate weight management, control of diabetes and avoidance of excessive substance use can therefore support treatment.

Pornography and Ejaculatory Timing

This subject requires a balanced explanation.

Pornography cannot simply be declared the cause of every sexual problem.

However, in some patients with delayed ejaculation, partnered stimulation may differ greatly from the highly specific visual, fantasy or stimulation pattern used during solitary sexual activity.

When that mismatch appears clinically relevant, reducing dependence on one highly specific arousal context and broadening sexual stimulation may form part of psychosexual treatment. The EAU specifically includes recalibrating mismatches between fantasy or pornography-related stimulation and partnered arousal among possible DE interventions.

The goal should be individualized assessment rather than moral judgment.

The Unani Understanding of Ejaculatory Disorders

The Unani system of medicine has traditionally approached sexual and reproductive health within a broader understanding of constitutional state, lifestyle, physical strength and psychological well-being.

Official Ministry of AYUSH material describes Unani medicine as emphasizing the **psychosomatic relationship between mind and body** and an individualized understanding of temperament, or *Mizaj*. It also describes the **Asbab-e-Sitta Zarooriya**, six essential health factors involving air, food and drink, physical activity and rest, sleep and wakefulness, retention and elimination, and mental well-being.

This holistic framework is relevant to sexual medicine because ejaculation does not occur independently of the rest of the person.

Sleep matters.

Emotional tension matters.

Relationship circumstances matter.

General metabolic health matters.

Physical fitness matters.

And reproductive goals matter.

Asbab-e-Sitta Zarooriya and Sexual Health

In Unani practice, maintaining appropriate balance in the essential determinants of health is considered important for both prevention and treatment.

From a modern integrative perspective, I find several aspects especially relevant.

A patient with chronic sleep deprivation may have more anxiety and poorer sexual confidence.

A sedentary patient with uncontrolled diabetes may have neurological and vascular complications.

A person under intense psychological stress may experience performance anxiety.

An unhealthy dietary pattern may contribute to obesity and metabolic disease.

Addressing these issues does not replace PE or DE treatment, but it can improve the background in which sexual treatment is delivered.

The Ministry of AYUSH continues to describe lifestyle regulation, dietotherapy (*Ilaj bil Ghiza*), regimenal therapy (*Ilaj bit Tadbeer*) and psychological measures such as *Nafsiyati Tadbeer* as components of the Unani therapeutic framework.

The Role of Nafsiyati Tadbeer

The psychological dimension of ejaculation is especially important.

Performance anxiety can accelerate ejaculation.

Excessive self-monitoring can worsen PE.

Fear of failure can affect erection.

On the other side, intense control, difficulty "letting go" and anxiety around orgasm may contribute to delayed ejaculation in some patients.

The Unani concept of **Nafsiyati Tadbeer**, or psychological measures, therefore fits naturally within an integrative approach.

In modern clinical practice, however, I believe these traditional principles should be complemented by evidence-based psychosexual therapy when indicated.

A patient with serious anxiety, depression or another mental-health disorder should receive appropriate specialist care.

Can Unani Medicines Treat Premature Ejaculation?

Unani medicine has a longstanding tradition of treating sexual-health complaints, and individualized formulations may be used by qualified Unani physicians according to the patient's constitution, symptoms and associated conditions.

However, I believe it is important to communicate the evidence honestly.

Current high-quality international PE guidelines have stronger evidence for specific pharmacological and psychosexual interventions than for any particular Unani formulation. There is not yet comparable high-quality evidence establishing one Unani herbal medicine as a universal cure for premature ejaculation.

Therefore, my approach is **integrative and individualized**, rather than promising that one powder, capsule or Majoon will permanently cure every patient.

Unani care may be used to support appropriate aspects of general health, lifestyle, psychological balance and associated sexual complaints, while established medical treatment and behavioural therapy are incorporated when clinically necessary.

Can Unani Medicines Treat Delayed Ejaculation?

The same scientific caution applies even more strongly to delayed ejaculation.

Because DE can result from antidepressants, diabetes, neurological disease, pelvic surgery, relationship factors or very specific psychosexual patterns, a generic sexual tonic cannot reasonably treat every cause.

If a patient has acquired DE after starting an SSRI, for example, the treatment plan must address that medicine.

If diabetic neuropathy is responsible, diabetes and neurological complications matter.

If ejaculation occurs easily during masturbation but not during intercourse, psychosexual treatment may be particularly important.

Unani supportive treatment may be incorporated for appropriate general-health or associated complaints, but it should not replace diagnosis.

Why Herbal Medicines Must Also Be Used Carefully

The word “herbal” does not mean that a medicine can be taken without assessment.

Patients may have diabetes, hypertension, liver or kidney disease or may already be taking antidepressants, blood thinners or other medicines.

Sexual-health patients also frequently purchase several products simultaneously because they are desperate for quick improvement.

This can make it difficult to identify what is helping, what is causing adverse effects and what may be interacting with another medicine.

At Saira Health Care, I believe Unani pharmacotherapy should therefore be **individualized and supervised**, not used through random combinations.

My Approach at Saira Health Care

When a patient visits **Saira Health Care** with an ejaculation problem, I do not begin by simply asking:

“How many minutes do you last?”

That is only one small part of the evaluation.

I want to understand whether the patient has PE, DE, anejaculation, retrograde ejaculation or another sexual problem.

I determine whether the problem is lifelong or acquired.

I assess erection quality.

I consider desire and orgasm.

I ask whether ejaculation differs between masturbation and partnered sexual activity.

I review medication use.

I consider diabetes, thyroid disease, neurological symptoms, prostate or urinary complaints and previous surgery when relevant.

I ask whether the patient is trying to conceive.

And I assess whether anxiety, relationship conflict or unrealistic expectations are increasing the problem.

Only then do I design a treatment strategy.

The Saira Health Care Integrative Treatment Model

My clinical approach combines the areas that are relevant to the individual patient rather than treating every man identically.

A patient may primarily require behavioural training.

Another may need established PE pharmacotherapy.

Another has erectile dysfunction that must be treated first.

Another has prostatitis or thyroid disease.

Another developed DE after an antidepressant.

Another primarily requires psychosexual counselling.

Another couple is trying for pregnancy, which changes which treatments are appropriate.

In selected patients, individualized Unani lifestyle, dietary or medicinal support can be incorporated alongside these interventions.

Where specialist urology, psychiatry, endocrinology, pelvic-floor therapy, fertility treatment or psychosexual therapy is required, referral should form part of responsible care.

Why Fertility Is Always Considered in My Practice

Because my clinical work focuses on **sexual disorders and infertility**, I consider reproductive goals early.

Two men may present with identical PE symptoms, but their treatment priorities may be completely different.

One may have completed his family.

The other may be trying urgently for pregnancy.

A DE patient may be sexually satisfied but unable to provide semen through intercourse.

Another patient may have normal ejaculation but poor sperm quality.

These are different problems.

This is why sexual medicine and reproductive medicine should communicate rather than operate in isolation.

Contribution of Saira Health Care in Sexual Disorders and Infertility

A major difficulty in sexual medicine is that patients often delay treatment because of embarrassment.

Some men live with PE for ten or fifteen years.

Others purchase delay sprays and tablets without understanding their diagnosis.

DE patients may simply assume that having intercourse for a very long time means they are sexually “strong,” even when both partners are distressed.

Some infertility patients never tell their fertility doctor that ejaculation is actually the reason semen is not being deposited.

Through clinical consultation and patient education, **Saira Health Care** aims to make these conversations medically understandable and confidential.

Our emphasis is on explaining the condition, identifying its causes, considering both sexual and reproductive health, using Unani care responsibly where appropriate, and involving other specialists when necessary.

About Dr. Nizamuddin Qasmi

My professional work has a focused emphasis on sexual disorders, reproductive health and infertility.

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS, Hamdard University, Delhi
MD
CGO
Certificate in Infertility, MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility by MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health (ISRH, UNFPA)

This background supports an approach in which ejaculation problems are evaluated not only from a sexual-performance perspective but also through urological, reproductive, infertility, psychological and lifestyle considerations.

When Should a Man Seek Medical Advice?

An occasional unusually early or late ejaculation does not usually require extensive investigation.

Medical assessment becomes more important when the problem is persistent, causes significant distress, suddenly appears after previously normal sexual function, is associated with erection difficulty, involves pain or blood, follows pelvic surgery, occurs with neurological symptoms, appears after starting a medicine, prevents ejaculation entirely, interferes with fertility, or significantly affects the relationship.

A sudden acquired change deserves particular attention because it may provide a clue to an underlying medical or medication-related cause.

Frequently Asked Questions

How many minutes should a healthy man last?

There is no single ideal duration.

Diagnosis of PE should not be based on a stopwatch alone. Control, consistency, distress and relationship impact are also important. Current guidelines explicitly advise a multidimensional assessment.

Is ejaculation before penetration premature ejaculation?

It can represent severe PE when it occurs consistently, is difficult to control and causes distress. Proper assessment is recommended.

Is occasional early ejaculation normal?

Yes. Variable episodes can occur in healthy men, particularly with high excitement, stress or long periods without sexual activity. The EAU considers variable PE a possible normal variation.

Does masturbation cause premature ejaculation?

There is no good evidence that masturbation itself universally causes PE. Some behavioural patterns may influence arousal in individual patients, but lifelong PE has complex biological mechanisms.

Does masturbation cause delayed ejaculation?

Masturbation itself is not automatically the cause. In selected patients, however, becoming accustomed to a very specific stimulation pattern may contribute to difficulty ejaculating with a partner. This should be assessed without stigma.

Can anxiety cause premature ejaculation?

Yes, particularly acquired PE. Anxiety may also develop as a consequence of repeated PE, creating a self-reinforcing cycle.

Can anxiety cause delayed ejaculation?

It may contribute in some patients. Excessive performance monitoring can interfere with progressing naturally toward orgasm and ejaculation.

What is the best behavioural technique for PE?

Stop–start training is one of the best-known techniques and has supportive evidence. Squeeze techniques, sensate focus, mindfulness and couple therapy may also be considered. Overall, behavioural evidence is less consistent than drug evidence, and current guidelines often favor combining psychosexual treatment with appropriate medical treatment rather than assuming behavioural therapy alone will cure every case.

Can pelvic-floor exercises cure PE?

Some studies suggest benefit, but evidence is not strong enough to describe pelvic-floor strengthening as a universal cure. Pelvic-floor coordination and relaxation can also be important.

Can antidepressants help PE?

Some SSRIs delay ejaculation and are used for PE, depending on the drug and regulatory setting. They can also cause adverse effects and should be prescribed medically.

Can antidepressants cause delayed ejaculation?

Yes. Antidepressants, particularly serotonergic drugs, are recognized medication-related contributors to DE. Do not stop them abruptly; discuss the problem with the prescribing clinician.

Is delayed ejaculation the same as erectile dysfunction?

No. A patient with DE may have a firm erection but be unable to ejaculate. However, ED and DE can coexist.

Is delayed ejaculation harmful?

It is not necessarily physically dangerous, but persistent DE can cause frustration, exhaustion, sexual dissatisfaction and fertility difficulties. Its underlying cause may also require treatment.

Is there an approved medicine specifically for delayed ejaculation?

At present there is no FDA- or EMA-approved medicine specifically for DE, and evidence for several medications used off-label remains limited.

Can premature ejaculation cause infertility?

Usually not