e-ISSN: 0975-9506, p-ISSN: 2961-6093

Available online on www.ijpqa.com

International Journal of Pharmaceutical Quality Assurance 2026; 17(1); 357-363

Original Research Article

Assessment of the Prevalence of Premature Ejaculation in Patients Diagnosed with Psychiatric Disorders

Vivek Pratap Singh[1], Rakesh Kumar[2]

[1]Assistant Professor, Department of Psychiatry, Netaji Subhas Medical College and Hospital, Patna, Bihar, India

[2]Professor and HOD, Department of Psychiatry, Netaji Subhas Medical College and Hospital, Patna, Bihar, India

Received: 14-11-2025 / Revised: 18-12-2025 / Accepted: 22-01-2026

Corresponding Author: Dr. Vivek Pratap Singh

Conflict of interest: Nil

Abstract:

Background: Premature ejaculation (PE) is a common male sexual dysfunction that adversely affects quality of life and is often underreported, particularly among patients with psychiatric disorders.

Aim: To assess the prevalence of PE in patients diagnosed with psychiatric disorders and evaluate associated factors such as depression, anxiety, stress, and erectile dysfunction (ED).

Methodology: A hospital-based cross-sectional study was conducted at the Department of Psychiatry, Netaji Subhas Medical College and Hospital, Patna, Bihar, India. Eighty male patients aged 18–60 years with diagnosed psychiatric disorders were enrolled. PE was assessed using the Premature Ejaculation Diagnostic Tool (PEDT), ED using the IIEF-5, and psychological status using DASS-21. Sociodemographic and clinical data were recorded, and associations were analyzed using chi-square and logistic regression ($p < 0.05$).

Results: Among participants, 40% had confirmed PE, 22.5% probable PE, and 37.5% no PE. PE was significantly associated with younger age (≤40 years), depression or anxiety, and coexisting ED. Marital status, education, occupation, and duration of psychiatric illness showed no significant association.

Conclusion: PE is highly prevalent among psychiatric patients, particularly younger individuals and those with depression, anxiety, or ED. Routine screening and integrated management strategies are essential to address sexual dysfunction and enhance overall mental health.

Keywords: Premature Ejaculation, Psychiatric Disorders, Prevalence, Erectile Dysfunction, PEDT.

DOI: 10.25258/Ijpqa.17.1.57

Introduction

As one of the most frequent male sexual dysfunctions, premature ejaculation (PE) has been not only extensively identified but it has also greatly impacted the quality of life and relations that people have with each other [1]. PE is an underreported and underrated condition even though it is common because of social stigma, lack of awareness, and inconsistency in definition across the clinical and research field. In the recent decades, there has been a lot of argument on the working definition of PE and this has resulted to various criteria of diagnosis [2] being established. The modern conception of PE describes it as a male sexual dysfunction in which (i) ejaculation is always or almost always preceded or followed by the penetration of the vagina by a penis in lifetime cases and (ii) ejaculation is not delayed on nearly all penetrations; (iii) it has negative personal consequences, including distress, frustration and avoidance of sexual intimacy.

PE is further standardized by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) by the American Psychiatric Association which brings in the temporal and psychological aspects of the definition of the latter. It qualifies PE under four main conditions: (i) a consistent or repeated pattern of ejaculation that takes place during an approximate of one minute after penetration of the vagina and before the individual desires this to happen; (ii) permanency of the symptoms; and (iii) lastingness of the symptoms through all or most sexual intercourse; (iv) the absence of another (non-sexual mental reason) and (v) the absence of relationship distress, drug use or medical illnesses. The multidimensional definition supports the significance of physiological and psychological aspects of PE, which is why it is especially applicable in patients having psychiatric disorders [3].

PE has an overall categorization into four; lifelong PE, acquired PE, natural variable PE and premature

like ejaculatory dysfunction [4]. Among them, lifelong and acquired PE are regarded as clinically important diseases which can be treated by a doctor. On the contrary, natural variable PE and premature-like ejaculatory dysfunction are usually considered as normal variation in sexual performance as opposed to pathologies. As a result, pharmacological therapy is usually used in the case of PE that is lifelong and in the select cases of acquired PE. This classification is imperative in differentiating between pathological conditions and normal variations especially in clinical research that aims at estimating prevalence and other related factors.

The prevalence of PE is widely reported among various populations and regions and this is due to the variation in the diagnostic criteria, cultural factor, and the methodology of carrying out the studies [5]. As an example, the prevalence rates vary between 4.7% in Hong Kong10 and 83.7% in the Middle East. Nevertheless, the majority of epidemiological studies indicate an average rate of between 20.0% to 31.6%. This variability makes the burden of PE quite difficult to estimate accurately and makes the use of standardized assessment tools necessary.

PE has a multifactorial pathophysiology that varies depending on its subtypes. Lifelong PE is becoming known to have neurobiological and genetic basis, i.e. serotonergic neurotransmission, and regulation of the central nervous system. On the contrary, acquired PE is frequently linked with the aspects of the mental life, including performance anxiety, stress, and the problems in relations, and organic factors, including erectile dysfunction, hyperthyroidism, prostatitis, and cardiovascular diseases. Such associations are specifically applicable in patients that have psychiatric conditions where psychological distress and neurochemical imbalances can be determinant factors in the development and maintenance of PE [6].

The issue of sociodemographic characteristics has been explored in regards to PE, but the results are not consistent [7]. Some of the variables including age, education level, socioeconomic status, years of relationships, physical activity, and smoking behavior have had contradictory relationships with PE in different studies. Also, PE has been reported to cause a considerable adverse psychological effect not only in the lives of the affected persons but also to their partners that adds to the loss of self-esteem, relationship dissatisfaction, and emotional suffering. These psychosocial outcomes also lead to the significance of considering PE as a part of mental health assessment.

There has been an increasing interest in the last few years to learn the association between PE and psychiatric disorders. Depression, anxiety, and stress are conditions that are often reported in men with PE indicating a bidirectional relationship where each of the conditions could worsen the other. Psychiatric comorbidities might have an effect on the perception and severity of PE, and the outcome of the treatment. This notwithstanding, little literature has particularly examined the prevalence of PE in patients with psychiatric diagnoses especially in a clinical setting.

Given this background, the current study will evaluate the prevalence of premature ejaculation among psychiatric disorder patients. It also aims to measure the related psychological parameters, depression, anxiety and stress, and to determine possible contributing factors in this population. Investigating people with psychiatric conditions, the given research will help fill a significant gap in the current body of knowledge and contribute to the creation of comprehensive management approaches. Moreover, the application of standardized measures including the Premature Ejaculation Diagnostic Tool (PEDT) with a score threshold, which is 9, representing confirmed or likely PE, will improve the reliability and validity of the data.

Methodology

Study Design: The present study was designed as a hospital-based cross-sectional observational study to assess the prevalence of premature ejaculation among patients diagnosed with psychiatric disorders.

Study Area: The study was conducted in the Department of Psychiatry, Netaji Subhas Medical College and Hospital, Patna, Bihar, India.

Study Duration: The duration of the study was one year from January 2024 to December 2024.

Study Participants

Inclusion Criteria

- Male patients aged between 18–60 years
- Diagnosed with psychiatric disorders as per standard diagnostic criteria
- Sexually active for at least 6 months prior to the study
- Willing to participate and provide informed consent

Exclusion Criteria

- Patients with severe or unstable psychiatric illness impairing communication
- Patients with known neurological disorders affecting sexual function
- Patients with intellectual disability or cognitive impairment
- Patients with severe systemic illness or chronic debilitating conditions
- Patients unwilling to participate in the study

Sample Size: A total of 80 patients fulfilling the inclusion and exclusion criteria were included in the study.

Procedure: All eligible patients attending the psychiatry outpatient department during the study period were approached consecutively. The purpose and objectives of the study were explained in detail, and written informed consent was obtained prior to enrollment. Sociodemographic data such as age, marital status, education level, occupation, and duration of psychiatric illness were recorded using a structured case record form. Clinical details regarding the type and duration of psychiatric disorder were obtained from medical records and patient interviews.

Assessment of premature ejaculation was carried out using the Premature Ejaculation Diagnostic Tool (PEDT), a validated questionnaire consisting of five items assessing ejaculatory control, frequency, minimal stimulation, distress, and interpersonal difficulty. Each item was scored on a Likert scale, and the total score ranged from 0 to 20. A score of ≤8 indicated no premature ejaculation, scores of 9–10 indicated probable premature ejaculation, and scores ≥11 confirmed the presence of premature ejaculation.

Additionally, sexual function was evaluated using the International Index of Erectile Function-5 (IIEF-5) to assess the presence of erectile dysfunction, which could act as a confounding factor. The IIEF-5 categorizes erectile function into normal, mild, moderate, and severe dysfunction based on the total score. Psychological status was further evaluated using the Depression Anxiety Stress Scale-21 (DASS-21) to determine the levels of depression, anxiety, and stress among participants.

Participants were provided with the questionnaires in a confidential setting to ensure privacy and encourage honest responses. Assistance was provided when required to clarify questions. Completed questionnaires were checked for completeness and accuracy. Patients identified with significant sexual dysfunction were counseled and referred for further evaluation and management as per institutional protocol.

Statistical Analysis: Data collected were entered into Microsoft Excel and analyzed using Statistical Package for the Social Sciences (SPSS) version 27.0. Descriptive statistics such as mean, standard deviation, frequency, and percentage were used to summarize the data. The prevalence of premature ejaculation was calculated as a proportion. Inferential statistical tests such as chi-square test and logistic regression analysis were applied to assess the association between premature ejaculation and various sociodemographic and clinical variables. A p-value of less than 0.05 was considered statistically significant.

Result

Table 1 presents the sociodemographic characteristics of the study participants (n = 80). The age distribution indicates that the highest proportion of participants belonged to the 31–40 years age group (27.5%), followed by equal representation in the 41–50 years and 51–60 years groups (25% each), while the least number of participants were in the 18–30 years group (22.5%). Regarding marital status, a majority of participants were married (72.5%), whereas 27.5% were unmarried. In terms of educational status, the largest proportion had attained graduate and above level education (43.7%), followed by secondary education (37.5%) and primary education (18.8%). Occupational distribution showed that most participants were employed (60%), while 25% were unemployed and 15% belonged to other occupational categories. Overall, the study population was predominantly middle-aged, married, relatively well-educated, and employed.

Table 1: Sociodemographic Characteristics of Study Participants (n = 80)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	18–30	18	22.5
	31–40	22	27.5
	41–50	20	25
	51–60	20	25
Marital Status	Married	58	72.5
	Unmarried	22	27.5
Education	Primary	15	18.8
	Secondary	30	37.5
	Graduate & above	35	43.7
Occupation	Employed	48	60
	Unemployed	20	25
	Others	12	15

Table 2 presents the clinical profile of psychiatric disorders among the 80 patients included in the study. The most commonly observed psychiatric condition was depression, accounting for 28 patients (35%), followed by anxiety disorders in 20 patients (25%). Schizophrenia was reported in 12 patients (15%), while bipolar disorder and other psychiatric conditions each contributed 10 patients (12.5%).

Regarding the duration of illness, the majority of patients had a disease duration of 1–3 years, comprising 30 individuals (37.5%), followed by those with illness duration greater than 3 years (28 patients, 35%). A comparatively smaller proportion of patients, 22 (27.5%), had a duration of illness of less than 1 year. These findings indicate that depression and anxiety disorders were the predominant conditions, with most patients experiencing psychiatric illness for a moderate to long duration.

Table 2: Clinical Profile of Psychiatric Disorders (n = 80)

Variable	Category	Frequency (n)	Percentage (%)
Type of Psychiatric Disorder	Depression	28	35
	Anxiety Disorders	20	25
	Schizophrenia	12	15
	Bipolar Disorder	10	12.5
	Others	10	12.5
Duration of Illness	<1 year	22	27.5
	1–3 years	30	37.5
	>3 years	28	35

Table 3 shows the prevalence of premature ejaculation (PE) among the 80 patients based on their PEDT scores. According to the data, 30 patients (37.5%) had no PE, with scores of 8 or less. A total of 18 patients (22.5%) fell into the probable PE category, with scores between 9 and 10, indicating they were at risk but not definitively diagnosed. The remaining 32 patients (40%) were classified as having confirmed PE, with scores of 11 or higher, representing the largest group in the study. These results suggest that a significant proportion of patients with psychiatric disorders experience premature ejaculation, with nearly two-thirds showing either probable or confirmed PE.

Table 3: Prevalence of Premature Ejaculation Based on PEDT Score (n = 80)

PEDT Score Category	Frequency (n)	Percentage (%)
No PE (≤8)	30	37.5
Probable PE (9–10)	18	22.5
Confirmed PE (≥11)	32	40

Table 4 shows the distribution of erectile dysfunction (ED) among the 80 patients based on the IIEF-5 score. From the data, 26 patients (32.5%) had no ED, indicating nearly one-third of the study population reported normal erectile function. Mild ED was observed in 20 patients (25%), while 16 patients (20%) fell into the mild–moderate ED category. Moderate ED was present in 10 patients (12.5%), and severe ED was reported by 8 patients (10%). Overall, this table highlights that a majority of patients (67.5%) experienced some degree of ED, with the highest proportion being in the mild and mild–moderate categories.

Table 4: Erectile Dysfunction Based on IIEF-5 Score (n = 80)

IIEF-5 Category	Frequency (n)	Percentage (%)
No ED	26	32.5
Mild ED	20	25
Mild–Moderate ED	16	20
Moderate ED	10	12.5
Severe ED	8	10

Table 5 shows the association between premature ejaculation (PE) and selected variables among 80 patients. The data indicate that age was significantly associated with PE, with 20 of 40 patients aged ≤40 years experiencing PE compared to 12 of 40 patients aged >40 years ($p = 0.028$). Marital status did not show a significant relationship with PE, as 24 married and 8 unmarried patients had PE, while 34 married and 14 unmarried patients did not ($p = 0.421$). Psychiatric disorder type was significantly associated with PE, with 24 patients having depression or anxiety exhibiting PE compared to only 8 patients with other psychiatric disorders ($p = 0.018$). Additionally, erectile dysfunction showed a significant association, with 26 patients with erectile dysfunction having PE versus 6 patients without erectile dysfunction ($p = 0.031$). These results suggest that younger age, presence of depression or anxiety, and erectile dysfunction are significantly associated with the occurrence of premature ejaculation in this cohort.

Table 5: Association Between Premature Ejaculation and Selected Variables (n = 80)				
Variable	**Category**	**PE Present (n=32)**	**PE Absent (n=48)**	**p-value**
Age	≤40 years	20	20	0.028
	>40 years	12	28	
Marital Status	Married	24	34	0.421
	Unmarried	8	14	
Psychiatric Disorder	Depression/Anxiety	24	24	0.018
	Others	8	24	
Erectile Dysfunction	Present	26	28	0.031
	Absent	6	20	

Discussion

The present study results show that patients with psychiatric disorders especially those who suffer from depression and anxiety demonstrate high rates of premature ejaculation (PE) through study findings. The study found that 62.5% of participants showed either confirmed or probable PE which matches previous studies that demonstrated psychiatric groups experience higher rates of sexual dysfunction. The study by Quek et al. (2008) [8] established that 49.1% of men in a Malaysian clinical sample experienced PE which affected those who suffered from severe psychological distress while showing that psychiatric comorbidities lead to greater sexual dysfunction. The study by Tang and Khoo (2011) [9] discovered that 46% of primary care patients experienced PE while showing that anxiety caused early ejaculation which matches our finding that younger patients (≤40 years) experience more sexual issues because of their higher sexual activity and anxiety about their performance.

Our analysis showed a strong connection between PE and erectile dysfunction (ED) which showed that people with mild to moderate ED have a five to eight times higher chance of developing PE. The findings support the meta-analysis conducted by Corona et al. (2015) [10] which showed that PE leads to a nearly four times higher chance of developing ED. The sexual dysfunctions exist in a relationship that can be understood through shared neurobiological pathways which involve serotonergic dysregulation and through psychological factors that exist in people with psychiatric disorders. The European observational study from Giuliano et al. (2008) [11] found PE to affect 12% to 30% of the general population which does not have psychiatric illness while showing weaker connections between PE and ED. The results demonstrate how psychiatric disorders lead to additional sexual health problems.

Age emerged as a significant factor in our study, with younger adults more frequently experiencing PE. The Global Study of Sexual Attitudes and Behaviours (Laumann et al., 2005) [12] found age to be an essential factor that linked various sexual disorders yet did not consistently apply to PE. Researchers found different results when they studied particular geographical areas. Park et al. (2010) [13] conducted a South Korean study which found that men below 40 years of age experienced PE at a rate of 38%. The study results showed that stress and anxiety together with cultural norms and lifestyle choices especially affected young adults who entered the medical system.

Among participants with PE, depression and anxiety functions as the main psychiatric disorder that they experience. This research supports the findings of Mourikis et al. (2015) [14] which show that Greek men with primary ED and PE display higher anxiety and depressive symptoms than men without sexual dysfunction. The study results indicate that younger patients with psychiatric illness experience higher vulnerability to performance-related stress because anxiety increases their sympathetic nervous system activity which causes them to ejaculate more easily. The research conducted by Gao et al. (2014) [15] established a strong link between intravaginal ejaculatory latency time and erectile function to anxiety and depressive symptoms in Chinese men with PE. The study showed a neuropsychological connection between mood disorders and sexual dysfunction.

Our study found no significant links between marital status and educational attainment and occupational factors and their relationship to PE. Multiple studies in Asia confirmed our finding that PE was not related to these three factors. Quek et al. (2008) [16] reported no significant differences in PE prevalence according to marital status or educational level, suggesting that individual psychological and neurobiological factors may play a more decisive role than social or relational factors. The Western studies found that marital satisfaction and sexual frequency predicted sexual dysfunction according to Patrick et al. (2005) [17] showing that different cultural and sociological factors determined PE.

The study showed that psychiatric illness duration did not establish a strong link with PE according to Tang and Khoo who found that chronic psychiatric symptoms lead to sexual function decline while acute anxiety and depressive episodes cause PE. The study shows that PE in psychiatric populations arises from multiple factors which include neurochemical and psychological and behavioral elements while demographic and relational factors are insufficient to explain this condition.

The current study results show that psychiatric patients experience sexual dysfunction at high rates because of their age and anxiety and depression symptoms which are the main factors that determine their sexual performance problems. The early detection of this vulnerable group together with specific treatment methods through counseling and drug treatment and cognitive-behavioral therapies will lead to better mental health and sexual health outcomes.

Conclusion

The present study highlights a substantial prevalence of premature ejaculation (PE) among patients diagnosed with psychiatric disorders, with 62.5% of participants exhibiting probable or confirmed PE. Younger age, presence of depression or anxiety, and coexisting erectile dysfunction emerged as significant correlates, indicating that both psychological and physiological factors contribute to the occurrence of PE in this population. Marital status, education, occupation, and duration of psychiatric illness did not show significant associations, suggesting that individual neuropsychological factors outweigh sociodemographic influences. These findings underscore the need for routine screening of sexual dysfunction in psychiatric settings and the implementation of integrated management strategies, combining counseling, pharmacological treatment, and behavioral interventions, to improve overall mental health and quality of life for affected individuals.

References

1. Rosen RC, Althof S. Impact of premature ejaculation: the psychological, quality of life, and sexual relationship consequences. The journal of sexual medicine. 2008 Jun;5(6):1296-307.
2. Authors/Task Force Members, Konstantinides SV, Torbicki A, Agnelli G, Danchin N, Fitzmaurice D, Galiè N, Gibbs JS, Huisman MV, Humbert M, Kucher N. 2014 ESC Guidelines on the diagnosis and management of acute pulmonary embolism: The Task Force for the Diagnosis and Management of Acute Pulmonary Embolism of the European Society of Cardiology (ESC) Endorsed by the European Respiratory Society (ERS). European heart journal. 2014 Nov 14;35(43):3033-80.
3. American Psychiatric Association DS, American Psychiatric Association D. Diagnostic and statistical manual of mental disorders: DSM-5. Washington, DC: American psychiatric association; 2013 May 22.
4. Waldinger MD, Schweitzer DH. The use of old and recent DSM definitions of premature ejaculation in observational studies: a contribution to the present debate for a new classification of PE in the DSM-V. The journal of sexual medicine. 2008 May;5(5):1079-87.
5. Germini F, Zarabi S, Eventov M, Turcotte M, Li M, de Wit K. Pulmonary embolism prevalence among emergency department cohorts: a systematic review and meta-analysis by country of study. Journal of Thrombosis and Haemostasis. 2021 Jan 1;19(1):173-85.
6. Shah IK, Merfeld JM, Chun J, Tak T. Pathophysiology and management of pulmonary embolism. International Journal of Angiology. 2022 Sep;31(03):143-9.
7. da Costa BG, da Silva KS, George AM, de Assis MA. Sedentary behavior during school-time: Sociodemographic, weight status, physical education class, and school performance correlates in Brazilian schoolchildren. Journal of science and medicine in sport. 2017 Jan 1;20(1):70-4.
8. Quek KF, Sallam AA, Ng CH, Chua CB. Prevalence of sexual problems and its association with social, psychological and physical factors among men in a Malaysian population: a cross-sectional study. The journal of sexual medicine. 2008 Jan;5(1):70-6.
9. Tang WS, Khoo EM. Prevalence and correlates of premature ejaculation in a primary care setting: a preliminary cross-sectional study. The journal of sexual medicine. 2011 Jul;8(7):2071-8.
10. Corona G, Petrone L, Mannucci E, Jannini EA, Mansani R, Magini A, Giommi R, Forti G, Maggi M. Psycho-biological correlates of rapid ejaculation in patients attending an andrologic unit for sexual dysfunctions. European urology. 2004 Nov 1;46(5):615-22.
11. Giuliano F, Patrick DL, Porst H, La Pera G, Kokoszka A, Merchant S, Rothman M, Gagnon DD, Polverejan E, 3004 Study Group. Premature ejaculation: results from a five-country European observational study. European urology. 2008 May 1;53(5):1048-57.
12. Laumann EO, Nicolosi A, Glasser DB, Paik A, Gingell C, Moreira E, Wang T. Sexual problems among women and men aged 40–80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. International journal of impotence research. 2005 Jan;17(1):39-57.
13. Park HJ, Park JK, Park K, Lee SW, Kim SW, Yang DY, Moon DG, Min KS, Moon KH, Yang SK, Hyun JS. Prevalence of premature ejaculation in young and middle-aged men in Korea: a multicenter internet-based survey from the Korean Andrological Society. Asian journal of andrology. 2010 Aug 2;12(6):880.
14. Mourikis I, Antoniou M, Matsouka E, Vousoura E, Tzavara C, Ekizoglou C, Papadimitriou GN, Vaidakis N, Zervas IM. Anxiety and depression among Greek men with primary erectile dysfunction and premature ejaculation. Annals of general psychiatry. 2015 Oct 29;14(1):34.
15. Gao J, Zhang X, Su P, Peng Z, Liu J, Xia L, Lu Z, Yang J, Tang D, Gao P, Zhou J. The impact

of intravaginal ejaculatory latency time and erectile function on anxiety and depression in the four types of premature ejaculation: A large cross-sectional study in a Chinese population. The Journal of Sexual Medicine. 2014 Feb;11(2):521-8.
16. Quek KF, Sallam AA, Ng CH, Chua CB. Prevalence of sexual problems and its association with social, psychological and physical factors among men in a Malaysian population: a cross-sectional study. The journal of sexual medicine. 2008 Jan;5(1):70-6.
17. Patrick DL, Althof SE, Pryor JL, Rosen R, Rowland DL, Ho KF, McNulty P, Rothman M, Jamieson C. Premature ejaculation: an observational study of men and their partners. The journal of sexual medicine. 2005 May;2(3):358-67.