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REVIEW

Behavioral Therapies for Management of Premature Ejaculation: A Systematic Review

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ABSTRACT

Introduction. Premature ejaculation (PE) is defined by short ejaculatory latency and inability to delay ejaculation causing distress. Management may involve behavioral and/or pharmacological approaches.
Aim. To systematically review the randomized controlled trial (RCT) evidence for behavioral therapies in the management of PE.
Methods. Nine databases including MEDLINE were searched up to August 2014. Included RCTs compared behavioral therapy against waitlist control or another therapy, or behavioral plus drug therapy against drug treatment alone. [Correction added on 10 September 2015, after first online publication: Search period has been amended from August 2013 to August 2014.]
Main Outcome Measure. Intravaginal ejaculatory latency time (IELT), sexual satisfaction, ejaculatory control, and anxiety and adverse effects.
Results. Ten RCTs (521 participants) were included. Overall risk of bias was unclear. All studies assessed physical techniques, including squeeze and stop-start, sensate focus, stimulation device, and pelvic floor rehabilitation. Only one RCT included a psychotherapeutic approach (combined with stop-start and drug treatment). Four trials compared behavioral therapies against waitlist control, of which two (involving squeeze, stop-start, and sensate focus) reported IELT differences of 7–9 minutes, whereas two (web-based sensate focus, stimulation device) reported no difference in ejaculatory latency posttreatment. For other outcomes (sexual satisfaction, desire, and self-confidence), some waitlist comparisons significantly favored behavioral therapy, whereas others were not significant. Three trials favored combined behavioral and drug treatment over drug treatment alone, with small but significant differences in IELT (0.5–1 minute) and significantly better results on other outcomes (sexual satisfaction, ejaculatory control, and anxiety). Direct comparisons of behavioral therapy vs. drug treatment gave mixed results, mostly either favoring drug treatment or showing no significant difference. No adverse effects were reported, though safety data were limited.
Conclusions. There is limited evidence that physical behavioral techniques for PE improve IELT and other outcomes over waitlist and that behavioral therapies combined with drug treatments give better outcomes than drug treatments alone. Further RCTs are required to assess psychotherapeutic approaches to PE. **Cooper K, Martyn-St James M, Kaltenthaler E, Dickinson K, Cantrell A, Wylie K, Frodsham L, and Hood C. Behavioral therapies for management of premature ejaculation: A systematic review. Sex Med 2015;3:174–188.**

Key Words. Review; Systematic; Premature Ejaculation; Behavior Therapy; Psychological Therapy

Introduction

Premature ejaculation (PE) is a male sexual dysfunction characterized by short ejaculatory latency. PE can be either lifelong (primary, present since first sexual experiences) or acquired (secondary, beginning later). The 2014 update of the International Society for Sexual Medicine (ISSM) Guidelines for the Diagnosis and Treatment of Premature Ejaculation define PE as a combination of (i) ejaculation usually occurring within about 1 minute of vaginal penetration (for lifelong PE) or a clinically significant reduction in latency time, often to around 3 minutes or less (for acquired PE); (ii) inability to delay ejaculation; and (iii) negative personal consequences such as distress, bother, frustration, and/or the avoidance of sexual intimacy [1]. PE is similarly defined by Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) (2013) as ejaculation usually occurring within about 1 minute of vaginal penetration and before the individual wishes it and causing clinically significant distress [1]. Estimating the prevalence of PE is not straightforward due to the difficulty in defining what constitutes clinically relevant PE. Surveys have estimated the prevalence of Diagnostic and Statistical Manual of Mental Disorders IV-defined PE as 20–30% [2–4]; however, these estimates are likely to include men who have some concern about their ejaculatory function but do not meet the current diagnostic criteria for PE [1]. It has been suggested that the prevalence of lifelong PE according to the ISSM and DSM-5 definitions (with an ejaculatory latency of about 1 minute) is unlikely to exceed 4% [1]. Men with PE are more likely to report lower levels of sexual functioning and satisfaction, and higher levels of personal distress and interpersonal difficulty, than men without PE [5]. They may also rate their overall quality of life as lower than that of men without PE [5]. In addition, their partner's satisfaction with the sexual relationship has been reported to decrease with increasing severity of the condition [6]. Management of PE may involve a range of interventions. These include systemic drug treatments (such as selective serotonin reuptake inhibitors, tricyclic antidepressants, phosphodiesterase type 5 inhibitors, and analgesics), topical anesthetic creams and sprays, and behavioral therapies (BTs) [7,8].

Behavioral and psychological therapies for PE include two main classes of therapy, with overlapping elements [1]. The first consists of psychotherapy (such as psychosexual or relationship counselling) for men and/or couples, to address psychological and interpersonal issues that may be contributing to PE. The second consists of physical techniques to help men develop sexual skills to delay ejaculation and improve sexual self-confidence. Specific physical techniques include the following. The "stop-start" technique, developed by Semans, involves the man or his partner stimulating the penis until he feels the urge to ejaculate, then stopping until the sensation passes; this is repeated a few times before allowing ejaculation to occur [9]. The aim is to learn to recognize the feelings of arousal in order to improve control over ejaculation. With the related "squeeze" technique, proposed by Masters and Johnson, the man's partner stimulates the penis until he feels the urge to ejaculate, then squeezes the glans of the penis until the sensation passes; this is repeated before allowing ejaculation to occur [9]. Within sensate focus or sensate focusing [7], the man and his partner begin by focusing on touch, which excludes breasts, genitals, and intercourse, to encourage body awareness while reducing performance anxiety; this is followed by gradual reintroduction of genital touching and then full intercourse [10]. Pelvic floor muscle rehabilitation exercises may also assist with ejaculatory control [11].

The aim of this study was to systematically review the evidence base for BTs in the management of PE.

Methods

Review Methods

The review was undertaken in accordance with the general principles recommended in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (http://www.prisma-statement.org/). The review protocol is available from the Health Technology Assessment Programme website (http://www.nets.nihr.ac.uk/projects/hta/131201).

Literature Searches

The following databases were searched up to August 2014: MEDLINE; Embase; Cumulative Index to Nursing and Allied Health Literature; The Cochrane Library including the Cochrane Systematic Reviews Database, Cochrane Controlled Trials Register, Database of Abstracts of Reviews of Effects and the Health Technology Assessment database; ISI Web of Science,