Review

Prevalence of Premature Ejaculation: A Narrative Review of National and Cultural Differences

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Abstract: The prevalence of premature ejaculation (PE) across different cultures and nationalities has long been a topic of debate, with early studies suggesting that men in such regions as the Middle East and Asia experience higher rates. However, the validity of these claims has been questioned due to methodological inconsistencies and the lack of comparative studies that apply uniform diagnostic criteria across different populations. This narrative review aims to analyze the existing literature to assess whether justifiable support for cultural or national differences regarding PE prevalance truly exists. The review focused on empirical studies spanning from 1995 to 2024 that included men from multiple nationalities or cultures. Studies on patient or specialized populations or that assessed only ejaculation latencies (EL) were excluded. Three categories of studies were reviewed: (1) studies including multiple nationalities within a single analysis, (2) studies from different countries that used an identical method to determine PE status, and (3) studies employing varied methodologies to determine PE status. The review found that differences in PE prevalence across cultures are more likely due to methodological variations than true cultural or national differences. While some trends, such as slightly higher rates in Latin American and Asian countries, were noted, no consistent patterns emerged. Studies using standardized methods, like the PEDT, generally showed prevalence rates between 5% and 15%, with no clear outliers across regions. Thus, current evidence does not support significant cultural or national differences in PE prevalence. Methodological inconsistencies, such as reliance on self-report and non-standardized diagnostic criteria, likely contribute to perceived differences. Future research should focus on using standardized methodologies and include more studies from underrepresented regions, such as Latin America and sub-Saharan Africa.

Keywords: premature ejaculation; prevalence; epidemiology; incidence; culture; cross-cultural

1. Introduction

Ever since seminal research on men's ejaculation latencies (EL) in 2008 across five nations (Netherlands, Spain, United Kingdom, USA, and Turkiye) reported that men from Turkiye showed the shortest ELs—sometimes half that of men from other national origins [1,2]—assumptions about population differences in PE prevalence across cultures/nations have abounded. Not only were men from the Middle East suspected of suffering disproportionately higher rates of PE, but—based on early prevalence research from other world regions—differences in other cultural/national groups were also suggested. For example, in the 2016 report of the International Consultation of Sexual Medicine [3], men from Asia and Latin America were pegged as having higher prevalence rates than men from the USA and Europe. At the same time, however, other authors disputed the validity of such assertions based on discrepant findings from their own prevalence studies [4,5].

Assumptions that differences in PE prevalence might exist across cultures/nationalities are not without justification. For example, cultural differences are well known to influence

men's and women's perceptions of what constitutes a sexual dysfunction, to what the dysfunction might be attributed (e.g., a somatic disease, lack of individual energy balance, divine punishment, etc.), and how the problem should be ameliorated (e.g., medical vs. spiritual healing) [6,7]. In addition, cultural expectations regarding sex roles during partnered sex could well affect pressures on performance [7,8]; and other factors, such as differences in circumcision rates across countries/cultures, might leave some groups of men more prone to PE due to differences in penile sensitivity (although see [9–11]).

Yet, assumptions and/or claims that *data* unequivocally support cultural/national differences in the prevalence of PE may, at this time, not be well founded. Specifically, the seminal studies upon which speculation about cultural differences was based [1,2] did not incorporate measures of ejaculatory control—the most critical criterion for PE [9,12]—and therefore inferences about PE prevalence based only on EL measures were not valid. Furthermore, few studies have adopted a comparative approach in assessing PE prevalence, that is, comparing prevalence rates across different countries/regions within a single analysis that applies identical recruitment strategies and definitional criteria to all included groups [8,13]; and those that have, have not generated consistent evidence supporting cultural differences. And, finally, studies originating from specific world regions (e.g., Europe, USA, Turkiye, China, Korea, etc. [4,5,9,13–18]) have often used different methodologies for determining PE status, thus confounding possible comparisons across cultures and countries. Despite these shortcomings, such cross-cultural investigation is critically important, given that the diagnostic criteria for PE are referenced to normative data indicating that men without PE have ELs between about 6 and 10 min [1,13,14,19,20]. Groups of men not fitting within this norm would likely be over- or under-diagnosed as having PE.

Rationale and Goals

The idea that men from different regions of the world might demonstrate different prevalence rates has not been given an adequate examination and vetting, due to the methodological issues that have arisen in the establishment of PE rates. In this review, we have attempted a more systematic and controlled approach to the idea that men from different world regions might exhibit different rates of PE, thus enabling greater confidence in comparisons across cultures/countries. To this end, we:

1. reviewed empirical studies that included men from more than one nationality or culture;
2. compared studies that drew men from *different* countries but that used an identical method for establishing PE status, specifically, the Premature Ejaculation Diagnostic Tool [21] "definite PE" categorization;
3. included a sampling of studies from different world regions but that used varying PE classification methodologies, thereby introducing a confounding variable to the analyses and thus demonstrating how comparison across such studies may result in misleading conclusions.

2. Materials and Methods

This narrative review addressed a topic that does not typically appear within the keyword sets of research papers. As an example, while many studies report prevalence data, keywords related to "cultural" or "cross cultural" or "national" or multicultural" or "multinational" are typically not included in the keyword set or in the article itself and therefore might have otherwise been missed as part of the bibliographic search. Thus, we conducted a literature search that included all review, position, and research papers related to epidemiology/prevalence in the area of PE, elaborating "premature ejaculation" with terms such as early and/or rapid ejaculation. In addition, citations referenced in identified sources were cross-checked with those identified through our bibliographic data searches, and references from all of these sources were cross-checked with papers in the authors' extensive personal libraries related to PE. Needless to say, overlap occurred in many of the searches. In many instances, because papers dealing with cultural differences in PE

prevalence were not identifiable as such, we scoured every paper in our final list of over 100 articles to uncover information germane to cross cultural differences in PE prevalence.

Our bibliographic search included published and indexed papers between 1995 and 2024, with resources including EBSCO (which includes but is not limited to Medline and PubMed), PsycArticles, PsycInfo, and Google, and Google Scholar. A list of keywords for these searches is included in Table 1. Only articles that included analyses or supporting information regarding prevalence in different countries/cultures have been included in this review. We excluded studies drawn from patient populations (*n* = 9) as these studies typically over-represent dysfunctional rates [22], consistently reporting rates over 15%, as well as studies on specialized populations such as medical students (*n* = 7) e.g., [23–27]. And we excluded studies that assessed only EL without including some measure of ejaculatory control, the PE diagnostic criterion considered most central to a PE diagnosis (n = 4) [1,9,12,14] as well as studies that included men with probable PE or did not report cut-off scores when the PEDT was used for PE classification (*n* = 3). Finally, our focus was on lifelong and/or acquired PE and did not consider other proposed PE categories, for example, variable PE, subjective PE, and subclinical PE [28,29].

Table 1. List of Keywords, used in various combinations, for bibliographic literature searches.

Group 1	Group 2 and/or 3	Qualifiers
Premature ejaculation Early ejaculation Rapid ejaculation Ejaculation latency Ejaculatory control	Prevalence Incidence Epidemiology Rate Lifelong/primary PE Acquired/secondary PE PE subtype PE etiology Multinational Cross cultural Cultural National Global	English language text or abstract Post 1995 through current Refereed paper Review or original research

3. Results

We have distinguished among three groups of studies regarding prevalence differences in PE across cultures/nations: (1) multiple nationalities represented within a single study; (2) studies from different world regions but sharing a common Patient Report Outcome (PRO) for establishing PE status, as the use of different PROs is a source of confounding variation [30]; and (3) studies from different world regions that used varied methods for establishing PE status.

3.1. Multiple Nationalities/Cultures Within a Single Study

The first group of studies examined multiple nationalities/cultures within a single study, by definition using a uniform methodology for defining PE status (Table 2). We identified five such studies in this grouping [8,9,13,31,32], with three reporting actual prevalence rates and the other two reporting national/regional differences in PE diagnostic parameters. Two of the multi-national prevalence studies used non-validated methods to assess PE so their results need to be interpreted with caution. Specifically, in a study where PE was self-defined or indicated by a lack of control over ejaculation, Porst et al. [31] reported overall high prevalence rates but with only minor variation across US, German, and Italian samples (24%, 20.3%, and 20% respectively). In contrast, Laumann et al. [32], using a single item asking about reaching climax (experiencing orgasm) too quickly, indicated much lower prevalence rates for "frequent" occurrence (2.5% to 8.3%), with European, Non-European West, and Middle East countries reporting low rates, 2.5% to 4.7%; Asian countries, 5.5%; and Central/South American countries 8.3%. A third multi-national as-

sessment of 9 Asian countries—the first to use the "definite PE" category of the validated instrument PEDT—reported an overall prevalence of 16%, with rates ranging from 3 to 33% [13]. The lowest prevalence rates were seen for Indonesia (3%) and China (4%), and the highest (33%) was reported for South Korea, leading to speculation that men from these various origins might be more or less prone to premature ejaculation e.g., [3].

Table 2. Multinational studies comparing PE prevalence or ejaculation latencies across world regions or nations.

Reference/Author	Sample Size	Data Collection Method	Definition/ Measure	Country	Outcome % or Min	Comment
Porst et al. (2007) [31]	12,133	Internet-based survey	PEPA PRO (ejaculatory control and distress)	Overall USA Germany Italy	22.7% 24.0% 20.3% 20%	
Laumann et al. (2005) [32]	13,618	Survey, phone, interview, door to door, etc.	Single Item, Self-report	Overall Northern Europe Southern Europe Non-Europe West Central/South America Middle East East Asia Southeast Asia	2.5–8.3% 3.2% 3.2% 4.7% 8.3% 2.5% 5.6% 5.4%	Randomized sample, includes % only for "frequent" occurrence, consistent with DSM, ICD, and ISSM definitions
McMahon et al. (2012) [13]	4997	Computer assisted interviewing, online or in-person self-completed	PEDT	Overall Australia/New Zealand China Hong Kong Indonesia Malaysia Philippines South Korea Taiwan Thailand	16% 22% 4% 6% 3% 10% 11% 33% 7% 13%	Sample not considered representative
Waldinger et al. (2009) [2]	474	Questionnaire	Clocked EL, median values	Overall Turkey UK Spain The Netherlands USA	6.0 min 4.4 min 10.0 min 4.9 min 6.5 min 8.1 min	Randomized sample

The other two studies reporting differences in PE diagnostic symptomology suggested only minor differences in PE characteristics across men from various countries or world regions. The rationale for including these studies was based on the idea that highly elevated median/mean baseline values for diagnostic criteria within specific world regions or countries could suggest either a higher prevalence rate or more severe PE symptomology for that region. The first of these studies included men from five European nations (France, Germany, Italy, Poland, and the UK) [9] and used the Premature Ejaculation Profile (PEP) [20,33] to establish PE status. This study reported only minor variations on two of the diagnostic criteria, perceived control over ejaculation and personal distress about the issue. On ELs, median values ranged from 1.5 to 3.5 min, with respondents from France and Italy showing higher values. However, this study concluded that differences in diagnostic parameters among the five European nations were likely due to the variation in sample sizes drawn from the different countries and did not reflect true national differences. The study further noted the similarity in rates to those obtained in a comparable study in the USA [12].

A second study [8] evaluated PE diagnostic criteria across three world regions in men identified with PE on the basis of ejaculatory control, bother/distress, and ejaculatory latency: North America/Europe; Sub-Saharan Africa; and ALL OTHER, which included Latin America, Oceania/South/East Asia, and Middle East/Western Asia. Median ELs for the three groups ranged between 2.0 and 3.0 min; and both "difficulty with ejaculatory control" and level of "bother/distress" showed only minor variation. Relevant to these measures, men from all six world regions reported—whether or not having PE—estimated median ELs for men with PE between 1.0 and 1.8 min, typical median ELs for men without PE between 6.0 and 8.5 min, and their own ELs between 5.0 and 8.0 min. In other words, no matter their origin, men from diverse world regions showed rather minimal differences in their estimations of typical ELs, PE ELs, and self ELs, results that argue that not only were assumptions about functional and PE ELs similar worldwide, but also that the PE diagnostic criteria (EL, ejaculatory control, and bother/distress) were perceived similarly across world regions. An exception emerged for Latin American men who showed expectations of significantly longer typical ELs and greater bother/distress related to shorter ELs than a North American/European reference group.

Section Summary

Overall, these studies suggest a wide range of prevalence rates, but generally variance in prevalence appears to result more from differences in methodological assessment of PE than to differences arising from national/regional/cultural origins. Two slight trends were suggested from the studies: Asian countries—South Korea in particular—and Latin American countries may have slightly higher prevalence rates compared to other world regions. Also notable, however, was the *lack* of consistently higher or lower rates for most world areas. For example, men from the Middle East, Australia, and several Asian countries—regions purported to show potentially higher PE rates in one set of analyses [1,13]—did not show similar patterns in other analyses [1,13,32]. Furthermore, studies assessing ELs did not reveal major differences across European or world regions, other than Latin American men estimating greater "normal/expected" ELs and "bother/distress" compared with North American/European counterparts [8], hinting that prevalence rates in this general region might be higher than other parts of the world.

3.2. World Regional or National Studies Using the PEDT to Establish PE Status

The second group of studies defined PE using an identical rubric for establishing PE status based on a PEDT score of ≥11 ("definite PE"), thus providing the opportunity to assess PE across various countries, including regions tagged as having abnormally high or low prevalence rates in the first set of studies described above. Some of these studies also combined a specific EL threshold with the PEDT categorization. We identified 21 studies meeting the ≥11 criterion which included (but was not restricted to) men from the USA, Canada, Hungary, Poland, Italy, Turkiye, India, China, South Korea, Singapore, and Brazil [4,5,16–18,34–45] (Table 3). From these studies, no particular world regions emerged as having unusually high or low PE rates; furthermore, these studies actually countered the anomalous rates reported in multi-national analyses within the first group of studies described above.

Table 3. Prevalence of PE in various countries using PEDT ≥ 11 for PE determination.

Reference/Author	Sample Size/Country	Data Collection Method	Definition/ Measure	Percent	Comment
Serefoglu et al. (2011) [40]	259 Turkiye	Interview	PEDT ≥ 11	6.2%	
Rowland et al. (2021) [35]	4432 USA/Hungary	Online survey	PEDT ≥ 11	7.5%	

Table 3. *Cont.*

Reference/Author	Sample Size/Country	Data Collection Method	Definition/ Measure	Percent	Comment
Rowland et al. (2023) [34]	2679 USA/Hungary	Online survey	PEDT ≥ 11	6.9%	
Shindel et al. (2012) [46]	2640 USA/Canada	Online survey	PEDT ≥ 11	8–12%	MSM group
Dos Reis et al. (2023) [47]	226 Brazil	Online survey	PEDT ≥ 11	21.2% 6.2% EL ≤ 2 min	MSM group
Dos Reis et al. (2022) [48]	564 Brazil	Online survey	PEDT ≥ 11	10.3% 1.6% EL ≤ 2 min	
Jiann (2016) [45]	937 Taiwan	Online survey	PEDT ≥ 11	11.3%	
Tsai et al. (2019) [49]	937 Taiwan	Online survey	PEDT ≥ 11	6.3%	
Grabski et al. (2019) [50]	1486 Poland	Online survey	PEDT ≥ 11	12.6%	Gay, bisexual
Gao et al. (2013) [42]	3016 China	Interview	PEDT ≥ 11	7.1%	
Hwang et al. (2013) [17]	290 South Korea	Survey	PEDT ≥ 11	12.1%	
Lee et al. (2013) [16]	2081 South Korea	Interview	PEDT ≥ 11	11.3%	
Karabakan et al. (2016) [5]	1230 Turkiye	Survey	PEDT ≥ 11	9.2%	
O'Sullivan et al. (2014) [36]	114 Canada	Online survey	PEDT ≥ 11	13.2%	Adolescents aged 16–21
Song et al. (2014) [44]	443 South Korea	Online survey	PEDT ≥ 11	14.6%	
Sathyanarayana et al. (2015) [41]	742 Indian	Survey	PEDT ≥ 11	8.8%	Minority of other nationalities
Levitan et al. (2019) [51]	185 USA/Canada	Online survey	PEDT ≥ 11	11.9%	Gay, bisexual
Santillán-Romero et al. (2024) [52]	315 Peru	Survey	PEDT ≥ 11	8.3%	MSM group
Przydacz et al. (2023) [37]	3001 Poland	Survey	PEDT ≥ 11	19.3%	

For example, the suggestion that Asian men might be more prone to PE than men from other world regions could be examined. Specifically, compared with the results of McMahon et al. [13] that reported a prevalence of 33%, three studies on Korean men showed rates of 11%, 12%, and 15% respectively [16,17,44], that is, rates that fell well within the typical ranges of most other countries. Rates in other Asian countries tended to follow suit: a somewhat dated study of men in Singapore indicated 20% prevalence [14], though McMahon et al. [13] in their comprehensive study of multiple countries in the broader Asian-Pacific region reported 16% prevalence. A PEDT-based study on a Chinese population reported a prevalence of about 8% [42], contradicting an earlier study showing a very low rate of 3% in that country [13]. Studies on men from Taiwan [45,49] recorded definite PE rates of 11.3% and 6.4%, while a study from the Asian subcontinent (India) reported a rate of 8.8% [41]. Overall, these studies show a range of about 7–16% prevalence, with an occasional outlier; and overall, no compelling patterns have emerged that would

suggest that Asian men—including men from South Korea and China—tend to fall above or below typical ranges. Along these same lines, within the Middle East, a region originally suspected of having a high rate of PE [1,2], two well-designed studies from Turkiye using a PEDT-based classification of PE reported prevalence rates of 6.2% and 9.2% [5,40].

PEDT-based studies from North America and Europe have generally confirmed minimal differences between PE rates in the USA, Canada, and Europe, and for the most part challenged the much higher rates (≥20%) initially reported by Porst et al. [31], which used self-identified or single item analysis for establishing PE status. Specifically, two studies on US and Hungarian populations reported rates of 6.9% and 7.5% for definite PE and ≤3 min EL, with no significant differences between the two populations [34,35], and a Canadian sample of 16–21-year-old respondents reported a prevalence of 13.2% [36]. Studies in the USA/Canada, Poland, and Peru on men having sex with men (MSM) or gay and bisexual men fell between 8 and 12.5%, showing general consistency over disparate world geographic regions [46,50,52]. An exception to these fairly moderate prevalence rates, a recent PEDT-based study of Polish participants reported a prevalence as high as 19.3% [51].

PEDT-based studies from Latin American countries are sparse, but two analyses have provided limited information on the issue. One indicated a prevalence of 10.3%, although when a second criterion of EL ≤ 2 min was added, this rate dropped to 1.6% [48]. In a second study on an MSM sample, a similar pattern was identified, with 21.2% indicating definite PE but that decreased to 6.2% when an EL criterion of ≤2 min was applied [47].

Section Summary

Data from individual countries situated in various world regions generally have not supported preliminary impressions of unusually high or low prevalence rates in some regions. Asian countries do not, on average, exhibit particularly high or low prevalence rates. Middle Eastern countries appear to fall within typical ranges. Western populations situated in North America and Europe, for the most part, show similar rates. And Latin American regions, although purported to have higher prevalence rates, appear to better conform with prevalence rates elsewhere when moderate restrictions are placed on EL values. Anomalies do persist, however, for example the possibility of higher rates in Eastern Europe, as reported by the Polish study [51], or in Latin America as noted by the Brazilian studies [47,48]. Such findings stress the need both for replication studies and for consensus regarding an adequate methodology for establishing PE status.

3.3. World Regional or National Studies Using Other Methodologies to Categorize PE

Estimates of prevalence in many studies, particularly earlier ones, were sometimes based on single item assessments (see [22,32]), self-assessed PE, or application of professional definitions, all of which can be problematic. Single item assessments have typically relied on simple statements such as "do you ejaculate before desired" [32]. Such items tend to inflate prevalence rates, with several recent studies [19,47,48] empirically demonstrating a common bias among men of wanting to "last longer" during intercourse: In these studies, men reported "ideal" ELs that were considerably longer than their actual (self-reported) ELs, independent of whether or not they had PE. In one study, for example, men without PE reported an ideal EL of 10 min, while reporting their own EL around 5–6 min. That is, men often subscribed to the idea that "longer is better", whether or not they had PE.

Reliance on self-assessment of PE status also appears to provide inconsistent estimates of PE prevalence, and may either under- or over- estimate its occurrence [13,16]. Error based on self-report is not surprising: Some respondents may be unfamiliar with PE symptomology and therefore not recognize their condition as such (leading to underestimation), or conversely, some may feel social pressure to last longer, subscribing to a "macho" cultural script related to "duration/stamina" (leading to overestimation).

Reliance on professional definitions, such as DSM [53] or ISSM [54] presents problems as well, as they do not operationalize criteria such as "ejaculatory control" or "bother/distress".

As such, they require either specification of how they have been operationalized (which may differ across studies), or a subjective interpretation and application of the criteria, which are likely to vary across expert clinicians and settings. Nevertheless, studies using these other methodologies (single-item, self-assessment, professional definitions, etc.) warrant examination, particularly when they incorporate rigorous or novel methodologies that potentially increase the accuracy of those classified as having PE.

The problem with self-report/self-identified PE (often using a single item) is readily seen by the high prevalence rates that often characterize such studies (Table 4), for example, 64.7% in Ghanian respondents [55], 34% in a US study on gay and bisexual respondents [56], nearly 83% in Arabic speaking respondents [57], 38.5% in Qatari respondents [58], 25.4% in South Korean men [43]; 27% in Norwegian respondents [59], 23% in Polish men [60], 49% in an Argentinian sample [24], and 25.8% in a Chinese population [42], this last rate notable because another study conducted in China the same year using self-report based on face-to-face assessment of PE symptomology reported a rate of only 4.7% [18]. Furthermore, several of the above studies also estimated PE rates using a validated PRO, allowing for direct comparisons across methodologies, with the latter methodology invariably showing considerably lower prevalence rates. However, with such high and wildly disparate percentages based on single-item self-report studies, it is no wonder that early PE prevalence ranges were often characterized as 30% or higher [22,61].

Table 4. Prevalence rates in studies using single items and/or self-report, showing the often-high estimates.

Reference/Author	Sample Size/Country	Data Collection Method	Definition/ Measure	Percent	Comment
Traeen & Stigum (2010) [59]	11,746 Norway	Survey	Single item, self-report	27%	
Amidu et al. (2010) [55]	255 Ghana	Survey	GRISS subscale and self-report	64.7%	
Hirshfield et al. (2010) [56]	7001 USA	Online survey	Single item, self-report	34%	Gay, bisexual
Mialon et al. (2012) [62]	2507 Switzerland	Questionnaire	PEPA PRO	11.4%	Men being assessed for military service
Shaeer & Shaeer (2012) [57]	6030 Arab speakers	Online survey	Self-report	82.6%	Majority of men had normal ELs
Gao et al. (2017) [63]	3016 China	Interview	Self-report	25.8%	
Zhang et al. (2013) [18]	728 China	Interview	Self-report of multiple symptoms	4.7%	
Lew-Starowicz et al. (2019) [60]	506 Poland	Survey	Single item, self-report	23.0%	
Albakr et al. (2021) [58]	3042 Quatar	Survey	Self-report, or AIPE PRO	38.5% self-report 36.2% AIPE	PE cut off on AIPE not reported/validated

Prior to or in place of validated PROs, a number of studies have used professional definitions (e.g., DSM [53], ISSM [54], ICD [64,65]) for PE classification in order to determine prevalence (Table 5). Several studies relying on PROs other than the PEDT have also been used, although comparisons across studies using different PROs are problematic as different PROs (e.g., PEDT, PEP, IPE, and CHEES [21,33,66,67]) ascribe different weights to various PE diagnostic criteria [30], further contributing to variation in PE prevalence estimates. Nevertheless, both methodologies (i.e., using professional definitions and using other

PROs) for establishing PE status tend to generate prevalence rates somewhat comparable to those obtained with the PEDT, for example, rates of 15.3% in China [68], 12% and 16.3% in the USA [20,69], 16% in Canada [70]; 7.9% and 18.3% in South Korea [71,72]; 7% and 10% in Denmark [73,74]; 17.7% in Greece [75]; 10.9% and 11.4% in Switzerland [62,76], and 4.7% and 9.2% in Germany depending on the level of patient distress [77]. Although the range of rates is considerable (5% to 18%), from this set of studies, no countries stand out as outliers or support early studies suggesting anomalous rates in various regions.

Table 5. Prevalence estimates from single-country studies using other PROs, multiple item assessments, professional definitions, or only EL criteria (last entry).

Reference/Author	Sample Size/Country	Data Collection Method	Definition/ Measure	Percent	Comment
Rowland et al. (2004) [69]	1158 USA	Online survey	DSM-IV-TR criteria	16.3%	Community sample
Patrick et al. (2005) [20]	1587 USA	Clinical examination	DSM-IV-TR criteria	12.2%	Community based sample
Briken et al. (2020) [77]	2206 Germany	Survey	ICD-11 criteria	4.7% severe 9.2% mod + severe	Probability sample
Brock et al. (2009) [70]	3816 Canada	Online + phone interview	DSM-III criteria	16%	Representative sample
Liang et al. (2010) [68]	12,743 China	Survey	ISSM criteria	15.3%	Population cross-section
Park et al. (2010) [71]	2037 South Korea	Survey	Korean Androl Society criteria	7.9%	Stratified sampling
Son et al. (2010) [43]	600 South Korea	Online survey	DSM-IV-TR criteria	18.3%	
Son et al. (2011) [72]	334 South Korea	Online survey	ISSM criteria	25.4%	
Christensen et al. (2011) [73]	2573 Denmark	Interview + questionnaire	DSM-IV-TR criteria	7.0%	Representative sample
Vakalopoulos et al. (2011) [75]	522 Greece	Survey	ISSM criteria lifelong PE only	17.7%	Population-based cohort
Akre et al. (2014) [76]	3695 Switzerland	Survey (mailed)	Control over ejaculation, distress	10.9%	
Andresen et al. (2022) [74]	28,583 Denmark	Survey	ICD-11	10.0%	Population study
Stulhofer and Bajic (2006) [78]	625 Croatia	Survey	EL < 2 min	9.5%	Stratified random sample

4. Discussion

As with individual studies themselves, several review papers on the epidemiology of PE have shown little consensus. For example, Irfan et al. [79] present prevalence ranges based on many studies, grouping data from Asia and Europe separately yet showing little difference across these two regions. Ranges in that review generally showed greater variance due to methodological differences than to Asian vs. European origin, with each group origin showing prevalence ranges between about 3% and 47%, an unhelpful range for deriving an overall credible prevalence. In an early review (2005), Jannini and Lenzi [80] suggested an overall rate of about 21%, noting possible higher rates in Asian and Latin American men, and potentially lower rates in men from the Middle East, presumably a collateral effect of religio-cultural factors. In a more recent review (2015), Saitz and Serefoglu [81] suggested a rate of only about 6–14% for combined lifelong and acquired PE but are mute about regional differences. In contrast, at about the same time (2106), McCabe et al. [3] reported a range of

6–30% in 2016, identifying Asia and Latin America as regions where prevalence appeared to be substantially higher. In a recent revisiting of the topic, Rowland et al. [22] argued that analyses that consider only studies having specific methodological improvements (e.g., using PROs, incorporating multiple criteria, avoiding self-identification) suggest a rate of combined lifelong and acquired PE of 6–10% for men with definite PE, and further, that the use of self-identification through single item responses, reliance on patient populations, or inclusion of men with "probable" PE tends to *add* another 10–15% to the prevalence rate. However, as with Saitz and Serefoglu [81], this study offers no assessment regarding world regional differences. As a group, these reviews do, nevertheless, underscore the difficulty of reaching a consensus range for prevalences rates *in general*, considering the methodological and rigor differences across studies, including the use of varying criteria, non-standardized measures, and sampling limitations. Thus, given the above disparities, such reviews further beg the question as to whether conclusions regarding different prevalence rates in different world regions could have any validity in a context where little consensus yet exists regarding overall prevalence rates.

4.1. Methodological Concerns

Given the typically high and often problematic prevalence rates generated by single-item self-report studies (e.g., 83%: [57]; or 65%: [55]), the question arises as to whether such values should ever be included in the calculation of overall prevalence rates. The lack of standardization of various PE criteria from PROs is also a problem; for example, not only does the use of ≥ 9 PEDT criterion double the rate compared to a criterion of ≥ 11 [35,38], but other PROs place different weightings on ejaculatory control vs. bother/distress. In fact, closer inspection of various anomalous prevalence rates often reveals specific methodological issues. For example, Tang & Khoo [25] reported a high prevalence rate (40.6%), but careful examination reveals that the sample size was small, the control measures were inadequate, and the subjects were drawn from the healthcare system. Shaeer and Shaeer [57] and Hanafy et al. [23] also present anomalous prevalence indices (e.g., 49.6%, 28%), yet examination of such studies reveals the lack fully replicable PE criteria or the focus solely on a patient population.

4.2. Drawing Conclusions About World Region and Cultural Differences

Given the above issues, most conclusions about differences in world region PE rates cannot be drawn with any degree of confidence. Although several early reports and reviews had suggested anomalous rates in men from Asia, the Middle East, and Latin America [1–3,32,80,82], consensus on such anomalies had been lacking [4,5,40]. Furthermore, the results of the current review offer little or no compelling evidence to support significant regional differences. For example, anomalous rates initially reported or assumed in Korean, Middle Eastern, and Chinese men have generally not been confirmed in subsequent studies. In fact, only data from Latin America suggest a higher prevalence rate in that population [8,47,48], although when the PE condition is restricted by an EL threshold of 1 or 2 min, the prevalence drops below 10%, thus falling in line with other world regions. At this point, the dearth of well-implemented prevalence studies from Latin America is notable, and more data are necessary to confidently infer higher PE prevalence rates in this world region.

Lacking from the literature are adequate data from sub-Saharan Africa. One study that assessed differences in PE diagnostic criteria across world regions found that sub-Saharan men not only placed greater emphasis on ejaculatory control than men from North America/Europe, but also reported greater bother/distress as well [8]. Such differences in baseline responding for men with and without PE regarding PE diagnostic criteria not only suggest possible differences in these populations, but also stress the dire need for well-designed prevalence studies from these world regions before drawing conclusions.

The current analyses would lead us to infer that religio-cultural variations are not particularly relevant to PE prevalence rates. However, we readily admit that we did not actually compare across groupings representing different cultural and religious traditions, as no data

exist to make such comparisons. Rather, we used national and world regional identities as proxies for various cultural representations, and such identities/boundaries do not always overlap with homogenous cultural or religious identities. Thus, while we can conclude with some confidence that existing data do not support the idea that PE prevalence differs across national or world regions, we are less confident in concluding that religio-cultural differences play no role in the likelihood of PE occurrence (and therefore, prevalence) [80].

4.3. Choosing an Adequate Methodology for Estimating PE Prevalence Across World Regions

The major issue with making prevalence comparisons across countries and/or world regions is the lack of a consistent and consensus methodology. Our review has revealed a number of methodological strategies that might be helpful for future studies on this topic. First, in addition to probability studies, prevalence studies should focus on community-based samples rather than patient samples or specialized groups that may contribute significant bias. To this point, Appendix A Table A1 provides a sampling of studies based on patient populations, and depicts the high and/or variable rates that are often generated by such studies [63,83–86]. These studies were not included as part of our larger analyses. Second, descriptions of methodology need to clearly specify whether the sample included men with lifelong PE or acquired PE, or both.

Our review has further noted the potentially inflated PE rates in studies using single-item and/or self-assessment—rates that, in our view, provide justifiable reason for their exclusion from the pool of prevalence studies. Studies employing professionally based definitions (e.g., DSM [53], ISSM [54], or ICD [65]), on the other hand, appear to generate more moderate and consistent PE rates (e.g., 6–20%), as do studies using multiple items or PROs that tap more than one dimension of PE. As such these methods represent a major methodological improvement over single-item self-identification. Furthermore, both methods (using professional definitions or validated PROs) typically assess both ejaculatory control—the primary defining criteria for PE [9,12,14,87]—and bother/distress [78]. Because two PROs—the PEDT [21] and CHEES [67]—offer the distinct advantage of providing suggested cut-off scores for categorizing men into definite and probable PE, they provide less opportunity for error variance than other PROs (e.g., PEP [33] or IPE [66]) that lack standardized cut-off scores for determining PE status.

In addition to assessing the constructs of "ejaculatory control" and "bother/distress", an adequate methodology should place a restriction on EL to eliminate respondents who might otherwise fall within the normal range of latencies. Studies that have done so, even when the restriction has been as high as 5 min, have generally reported substantially lower prevalence rates, in the range of 3–12% [16,17,34,39,42,47,48,50,88,89], although exceptions do occur [43].

4.4. Limitations

Our review included English language studies in indexed international publications, and thus the literature search was limited by these search parameters. Equally important, the vast majority of prevalence studies were based on community samples; few were based on probability samples. Sample sizes ranged greatly, from slightly over 200 to over 10,000, and our analysis did not weight studies based on this parameter. Third, our critical analysis focused on broad methodological issues related to variations in sample characteristics and procedures for PE categorization. We did not examine individual studies for other methodological issues, such as ones related to biases in age, education, specific recruitment procedures (other than elimination of studies based on patient populations or special pre-selected groupings), and so on. Accordingly, we focused on consistency across (and adequacy of) methodologies in broad groups of studies, deriving conclusions based on patterns of prevalence rates rather than on specific methodologies and rates unique to each individual study. Finally, we did not directly assess prevalence rates based on religio-cultural identities, but rather utilized national and world regional groupings as proxies for various cultural variations, the former not always fully overlapping with the latter.

5. Conclusions

Cross-cultural perspectives are critically important because the criteria for PE—from both the American Psychiatric Association and International Society of Sexual Medicine [53,54]—have relied heavily on research emanating from regions of the world having a "Western" orientation. However, the current lack of standardized methodology across studies currently presents a major challenge to drawing confident conclusions regarding world region differences in PE prevalence rates. Specifically, the extant literature generally does not support unusually large or small prevalence rates in Asian and Middle Eastern regions (compared, say, to North America and Europe). And additional studies from Latin American and sub-Saharan African regions need to be carried out before making assumptions about typical or anomalous prevalence rates in these world regions. We do not dismiss the possibility of world regional or cultural differences in PE prevalence rates but rather conclude that, given the state of the current literature, evidence supporting regional differences in PE prevalence is neither persuasive nor complete. Thus, as future studies are implemented, better and more consistent methodological procedures across studies tapping different world regions are needed for defining the population in question, determining PE status, and arriving at more confident estimates.

Author Contributions: Conceptualization, D.L.R. and S.T.; methodology, D.L.R., S.T. and Z.M.; validation, Z.M.; investigation, D.L.R., Z.M. and S.T.; resources, K.H.; data curation, D.L.R., S.T. and Z.M.; writing—original draft preparation, D.L.R., Z.M. and S.T.; writing—review and editing, D.L.R., Z.M., S.T. and K.H.; visualization, D.L.R., Z.M. and S.T.; supervision, D.L.R. and K.H.; project administration, D.L.R. and K.H.; funding acquisition, K.H. All authors have read and agreed to the published version of the manuscript.

Appendix A

Table A1. Examples of generally higher prevalence estimates in studies using patient or clinic samples.

Reference/Author	Sample Size/Country	Data Collection Method	Definition/ Measure	Percent	Comment
Dunn et al. (1998) [84]	617 UK	Postal survey	Single item, self-report	14%	General practice patients
Nolazco et al. (2004) [24]	2705 USA	Questionnaire	Self-report	49.3%	Participants in a healthcare campaign
Shindel et al. (2008) [86]	73 USA	Survey	Single item, self-report	50%	Clinic sample with infertile partners
Basile Fasolo et al. (2005) [83]	2658 Italy	Clinical examination	DSM-IV	21.2% lifelong PE	Andrology clinic patients
Mo et al. (2014) [85]	600 China	Interview	IELT < 2	30%	Prostatitis patients
Pozzi et al. (2021) [90]	2013 Italy	Medical history	ISSM criteria	16%	Patients' Initial assessment period
Hanafy et al. (2019) [23]	750 Egyptian	Clinical Interview	PEDT ≥ 11	28%	Dermatology & andrology patients
Verze et al. (2018) [39]	1103 Italy	Survey	PEDT ≥ 11	18.5%	Patient population

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