

The Hidden Half of Premature Ejaculation: Partner Factors and Shared Determinants – A Couple-Based Cross-Sectional Study

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Abstract

Objective

Premature ejaculation (PE) is one of the most common male sexual dysfunctions, yet it is often perceived as an individual disorder, despite growing evidence suggesting a couple-based pathophysiology. This study aimed to explore the shared demographic, behavioral, and psychosocial determinants of PE among heterosexual couples.

Materials and Methods

A cross-sectional study was conducted between 2023 and 2025, including 661 heterosexual couples (n = 1,322 individuals) attending a tertiary urology clinic. Participants completed validated instruments: the Arabic Index of Premature Ejaculation (AIPE), the Premature Ejaculation Diagnostic Tool (PEDT), the International Index of Erectile Function (IIEF-5), and the Intravaginal Ejaculatory Latency Time (IELT) was questioned for males, and the Golombok–Rust Inventory of Sexual Satisfaction (GRISS) for females. PE was defined according to the AIPE and PEDT cutoffs. Logistic regression analyses were performed to identify predictors of PE among male participants, using both partners' variables.

Results

PE was identified in 272 (41.1%) men. Men with PE were significantly older, less physically active, and had lower educational levels than men without PE ($p < 0.05$). Female partners of men with PE were also older, more frequently affected by chronic comorbidities, and less likely to exercise regularly. Multivariate regression revealed that older age (OR = 1.057, 95% CI: 1.039–1.075, $p = 0.001$), physical inactivity (OR = 1.759, 95% CI: 1.126–2.749, $p = 0.013$), and low education level (OR = 2.224, 95% CI: 1.413–3.501, $p = 0.001$) were independent predictors of PE in men. Among women, age (OR = 1.04, 95% CI: 1.016–1.066, $p = 0.001$), comorbidities (OR = 2.639, 95% CI: 1.312–5.307, $p = 0.006$), and physical inactivity (OR = 2.995, 95% CI: 1.778–5.044, $p < 0.001$) were associated with an increased risk of PE in their partners.

Conclusion

PE should not be accepted purely as a male-specific disorder. It should be regarded as a shared biopsychosocial condition influenced by the characteristics of both partners. Lifestyle modification, patient education, and couple-based counseling may improve ejaculatory control and relationship satisfaction. These findings highlight the importance of a comprehensive, couple-centered approach to PE management.

Introduction

Premature ejaculation (PE) is one of the most prevalent male sexual dysfunctions, affecting up to 30% of sexually active men worldwide (1). Despite its high frequency, PE remains one of the least understood and most stigmatized disorders in sexual medicine. The condition is traditionally defined as ejaculation that occurs sooner than desired, leading to personal distress or interpersonal difficulty. However, contemporary perspectives emphasize that PE extends beyond simple ejaculatory timing; it represents a complex biopsychosocial phenomenon affecting both partners within the sexual relationship.

While biological factors, such as serotonergic dysregulation, hormonal imbalance, and penile hypersensitivity, contribute to the pathophysiology of PE, increasing evidence suggests that psychosocial and relational dimensions play an equally important role. Factors including age, education, emotional intimacy, communication quality, and lifestyle behaviors can either mitigate or exacerbate PE symptoms. However, prior research has focused mainly on male characteristics (2–3). The role of relational and partner-related factors has received less attention. Consequently, the contribution of female partners' demographics, health status, and psychosocial profiles to PE remains insufficiently explored.

Recent studies have highlighted this gap, and they also demonstrated that couple-level factors, including poor sexual communication, relationship dissatisfaction, and female sexual dysfunction, may contribute to the persistence of PE (4–5). Similarly, recent meta-analyses have shown that lifestyle factors, including physical inactivity and low educational levels, are strongly associated with sexual dysfunction in both men and women (6). These findings suggest that PE should not be viewed only as an individual male disorder; it should be considered a shared outcome of the couple's biopsychosocial environment. The present study aimed to explore this couple-centered perspective by examining the relationship between the demographic, behavioral, and psychosocial factors of both partners and the presence of PE. We aimed to combine male and female data to identify modifiable risk factors. The influence of partner-related characteristics on ejaculatory control was also assessed. This approach offers a more comprehensive understanding of PE as a shared condition and may inform prevention and treatment strategies through joint lifestyle modification and couple-based interventions.

Materials and Methods

The study protocol was approved by the local ethics committee (Tekirdag Namık Kemal University Non-Interventional Clinical Trials Ethical Committee, Number: 2024.99.05.07) and conducted in accordance with the Declaration of Helsinki. This research was carried out under the auspices of the Andrology Working Group of the Society of Urological Surgery in Turkey.

This multicenter cross-sectional study was conducted between 2023 and 2025 at urology clinics. A total of 1,322 individuals (661 couples) were evaluated. The eligible participants were heterosexual couples in a stable relationship for at least six months. Exclusion criteria included major psychiatric disorders, history of pelvic surgery, use of medications affecting ejaculation or sexual function, and uncontrolled systemic diseases. All participants provided written informed consent before participation.

All participants completed a questionnaire with interviewer at outpatient and we assessed the sociodemographic characteristics (age, education, marital status, income, and lifestyle factors, such as smoking, alcohol use, and exercise habits). Male participants were assessed using the Arabic Index of Premature Ejaculation (AIPE), the Premature Ejaculation Diagnostic Tool (PEDT), the Intravaginal Ejaculatory Latency Time (IELT), and the short version of the International Index of Erectile Function (IIEF-5) to evaluate erectile status. Female partners completed the Golombok–Rust Inventory of Sexual Satisfaction (GRISS) and Sexual Relationship PowerScale (SRPS) which assessed communication, frequency, touch, and satisfaction. All surveys were administered in their validated versions, and questionnaire forms are available in the supplementary material (7–9).

Clinicodemographic data, comorbidities, and lifestyle data were recorded for both partners. PE was defined according to the AIPE and PEDT cutoff values consistent with clinical diagnostic criteria. Comorbidities included diabetes, hypertension, and other chronic systemic diseases. Physical activity was categorized as regular (≥ 3 sessions/week) or irregular (< 3 sessions/week). Educational level was dichotomized as “high school or lower” versus “university or higher” for comparative analysis. Household income groups were defined according to the latest nationally reported poverty and hunger thresholds.

Statistical Analysis

Categorical variables were expressed as frequencies and percentages, and continuous variables as medians (Q1–Q3). The Shapiro–Wilk test was used to assess the normality of the continuous variables. The Mann–Whitney U test was used to compare distributions between groups, and the chi-square test was used to compare the distribution of categorical variables. Simple logistic regression was used for bivariate analysis to identify individual associations with PE status (yes/no). Factors found to be significant in bivariate analysis were entered stepwise into a multiple logistic regression model. Significant results are presented as odds ratios (ORs) with 95% confidence intervals (CIs). Nonsignificant covariates were removed from the model. All statistical analyses were performed using SPSS 19.0 software (IBM Corp.). A p-value of < 0.05 (two-tailed) was considered statistically significant.

Results

A total of 1,322 individuals (661 couples) participated in the study. Premature ejaculation was reported in the male partners of 272 couples, whereas it was absent in 389 couples. Thus, 661 men were included in the analysis: 272 had PE, and 389 did not.

Men with PE were significantly older than those without PE (median age, 44 vs. 31 years; $p = \mathbf{0.001}$). They were less likely to engage in regular physical activity and had lower levels of educational attainment. Alcohol consumption was significantly more common among men without PE (59.6% vs. 44.1%; $p = \mathbf{0.001}$). Consistent with the clinical diagnosis, individuals in the PE group had significantly lower AIPE scores than those without PE (19 vs. 31; $p = \mathbf{0.001}$) and shorter IELT durations (3.6 ± 2.8 vs.

11.8 ± 4.5 min; $p = \mathbf{0.001}$). In contrast, no statistically significant difference in IIEF scores was observed between the two groups (Table 1).

Table 2 presents a comparative analysis of female partners according to whether their male partners had PE. Women whose partners had PE were significantly older (median age, 43 vs. 30 years; $p = \mathbf{0.001}$), had higher body weight (68 vs. 60 kg; $p = \mathbf{0.001}$), and exhibited more comorbidities (73 vs. 27; $p = \mathbf{0.001}$). Alcohol consumption and lower engagement in regular physical activity were also more common among women with PE partners ($p = \mathbf{0.001}$ and $p = \mathbf{0.002}$, respectively). A greater proportion of women with PE partners were currently married and had children compared to those without PE partners. The educational level distribution showed a lower rate of university graduates and postgraduate degrees among women with PE partners ($p = \mathbf{0.001}$). No significant differences were observed in having a private room (i.e., a separate bedroom allowing sexual privacy) or in combined household income (Table 2). Women with partners with PE had significantly lower scores in sexual frequency, communication, touch, satisfaction, relationship quality, and anorgasmia ($p = \mathbf{0.001}$). However, no significant difference was observed between the groups in vaginismus ($p = 0.127$). In the analysis of the Sexual Relationship Power Scale (SRPS), relationship control and total SRPS scores were significantly higher in women with a PE partner ($p = \mathbf{0.001}$), whereas no significant difference was found in decision-making dominance ($p = 0.054$) (Table 5, Figure 1)

The multivariate logistic regression model explained 27.7% of the variance in PE presence among men. Increasing age was associated with higher odds of PE, with each additional year increasing the likelihood by 5.7% (OR = 1.057, 95% CI: 1.039–1.075; $p = \mathbf{0.001}$). Men who did not engage in regular physical activity had 1.76-fold higher odds of PE (OR = 1.759, 95% CI: 1.126–2.749; $p = \mathbf{0.013}$). In addition, lower educational attainment (high school or below) was associated with 2.22 times the odds of PE compared with university-level education or higher (OR = 2.224, 95% CI: 1.413–3.501; $p = \mathbf{0.001}$) (Table 3, Figure 2).

The multivariate logistic regression model for female partners' characteristics explained 32.7% of the variance in the presence of PE in their male partners. Each one-year increase in age was associated with a 4% increase in the likelihood of PE in their partners (OR = 1.04, 95% CI: 1.016–1.066; $p = \mathbf{0.001}$). The presence of comorbidities in female partners increased the odds of PE in their male partners by 2.64 times (OR = 2.639, 95% CI: 1.312–5.307; $p = \mathbf{0.006}$). Similarly, a lack of regular exercise was associated with 2.19-fold higher odds (OR = 2.188, 95% CI: 1.284–3.73; $p = \mathbf{0.004}$). Women with a high school education or lower had nearly three times greater odds of having a partner with PE compared with those with university-level education or higher (OR = 2.995, 95% CI: 1.778–5.044; $p < \mathbf{0.001}$) (Table 4 and Figure 2).

Discussion

This study demonstrates that premature ejaculation (PE) should not be regarded only as a male-specific disorder but rather as a shared condition influenced by the combined demographic, behavioral, and

psychosocial characteristics of both partners. The findings indicate that PE develops within an interpersonal context in which biological vulnerability interacts with mutual habits, communication patterns, and lifestyle factors that influence the couple's sexual functioning.

One of the main findings was that older age was strongly associated with PE. This outcome is consistent with a previous trial reporting that each additional year increases the odds of PE by approximately 6% (10). This association may partly reflect age-related declines in hormonal activity, nerve conduction, and penile sensitivity. Similarly, earlier studies have shown that older female partners tend to report higher levels of sexual dissatisfaction and more frequent orgasmic difficulties, which may increase relational stress and contribute to ejaculatory problems in male partners (4, 11).

Education level also played a significant role in the frequency of PE. In our data, men with a high school education or lower exhibited a 2.2-fold increase in the prevalence of PE. Female partners with the same educational background were associated with a nearly threefold increase in their partners' PE risk. Grewal et al. (2014) observed similar results in South Asian populations, linking low education and limited sexual communication with a higher PE prevalence (5). A lower level of education is often linked to reduced health literacy and a limited ability to engage in effective communication between partners. This may lead to misunderstandings, avoidance of sensitive discussions, and a lack of shared problem-solving, all of which can negatively affect sexual and emotional well-being within the relationship.

Physical inactivity was another key predictor. Men who did not exercise regularly had a 1.76-fold higher likelihood of PE, while inactive women increased their partners' risk by 2.19-fold. A recent review by Allen and Walter (2018) supported our observations, showing that moderate and high levels of physical activity reduced the risk of sexual dysfunction by 37% and 58%, respectively (6). Exercise may help improve vascular and hormonal regulation, reduce anxiety, and enhance ejaculatory control.

Female comorbidities also played a significant role in couples affected by PE. Chronic diseases in women increased the risk of PE in their male partners by 2.64 times. Previous studies have confirmed this association. According to Ibrahim (2012) and Yanez (2006) et al., female aging and chronic illness correlate with lower sexual desire and satisfaction, which may indirectly affect male ejaculatory control through relational dynamics (4, 11). The interaction between partners appears to be reciprocal—sexual dysfunction in one partner often mirrors and contributes to emotional or health difficulties in the other. Relationship quality also appeared markedly reduced. In couples affected by PE, GRISS scores for communication, touch, frequency, and satisfaction were clearly lower than in those without PE. This finding aligns with the observations of Ventus et al. (2021), who observed that such couples were two to three times more likely to experience reduced satisfaction and emotional withdrawal (2). Overall, PE may undermine emotional closeness and mutual trust, creating a psychosexual effect that extends past the individual to both partners.

In summary, our data and previous studies converge on a single conclusion: PE is a multifactorial condition influenced by shared lifestyle and emotional factors (4–6, 10). Focusing on modifiable factors, such as education and exercise, may improve ejaculatory control. When combined with couple-based

counseling, these efforts can also improve relational satisfaction. Although our cross-sectional design limits causal inference, the large sample and inclusion of partner variables provide strong evidence that PE represents a shared phenomenon rather than an isolated male issue. Further studies are needed to evaluate the longitudinal impact of partner-related factors on PE and to assess the clinical effectiveness of couple-based therapeutic interventions.

Conclusion

This study demonstrates that PE emerges within a shared interpersonal and behavioral context rather than as an isolated male condition. Both male and female factors—including age, education, lifestyle habits, and health status—contribute to its manifestation. Addressing modifiable parameters, such as physical inactivity and low educational attainment, combined with couple-focused counseling, may improve ejaculatory control and mutual satisfaction. Future longitudinal and interventional studies are warranted to clarify causal mechanisms and develop preventive, lifestyle-based therapeutic strategies that integrate both partners into the management of PE.

Declarations

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Human Ethics and Consent to Participate: A written informed consent was obtained from participants to participate in the study. All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Conflicts of Interest

The authors declare no conflicts of interest.

Author's contribution

C.D. conceived the study, designed the methodology, supervised the project, and contributed to data interpretation and manuscript drafting. D.S. performed the main statistical analyses, oversaw analytic strategy, contributed to data interpretation, and critically revised the manuscript. M.F.S. supported statistical modeling, assisted with data interpretation, and contributed to manuscript preparation. C.M.Y. coordinated data acquisition, supported methodological processes, and reviewed the manuscript. A.B. curated clinical data, conducted literature review, and contributed to manuscript editing. A.Y. participated in patient data collection, clinical assessment, and manuscript review. M.S.K. managed the database,

supported analytic workflows, and assisted in proofreading. F.B.T. prepared figures, organized data, and provided technical support. O.C. offered clinical oversight, methodological input, and critical revision. A.C. provided software support, managed the digital survey infrastructure, and contributed to data processing. All authors reviewed and approved the final manuscript.

Data Availability Statement

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

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Tables

Table-1. Comparison of Demographic and Sexual Function Parameters Between Men with and without PE

	Men with PE (n=272)	Men Without PE (n=389)	p value
Age (year) (median, IQR)	44 (34-56)	31 (24-41)	0.001
Height (cm) (median, IQR)	176 (168-183)	178 (175- 184)	0.001
Weight (kg) (median, IQR)	81 (75-93)	83 (74-94)	0.342
Comorbidities (Yes/no)	54 / 218	59 / 330	0.417
Alcohol consumption (Yes/No)	120 (44.1%) / 152 (55.9%)	232 (59.6%) / 157 (40.4%)	0.001
Regular physical exercise (Yes/No)	86 (31.6%) / 186 (68.4%)	205 (52.7%) / 184 (47.3%)	0.001
Education level (n, %)			0.001
Primary school	59 (21.7%)	16 (4.1%)	
Middle school	47 (17.2%)	18 (4.6%)	
High school	65 (23.9%)	75 (19.3%)	
University	84 (30.9)	237 (61%)	
Master's degree	17 (6.3%)	35 (9%)	
Doctorate	0 (0%)	8 (2%)	
AIPE (median, IQR)	19 (16-24)	31 (27-32)	0.001
PEDT (mean ± SD)	14.68 ± 5.44	4.35 ± 2.11	0.001
IELT (min) (mean ± SD)	3.6 ± 2.8	11.8 ± 4.5	0.001
IIEF (median, IQR)	23 (21-24)	22 (20-24)	0.785

* **AIPE:** Arabic Index of Premature Ejaculation, **IIEF:** International Index of Erectile Function, **PEDT:** Premature Ejaculation Diagnostic Tool, **IELT:** intravaginal ejaculatory latency time

Table -2. Comparative Analysis of Demographic and Sexual Function Parameters in Female Partners According to the Presence of PE in Their Partners

	Women with a PE partner (n=272)	Women without a PE partner (n=389)	p value
Age (year) (median, IQR)	43 (31-56)	30 (22-41)	0.001
Height (cm) (median, IQR)	163 (158-169)	165 (160-170)	0.014
Weight (kg) (median, IQR)	68 (59-80)	60 (55-68)	0.001
Comorbidities (Yes/No)	73 (26.8%) / 199(73.1%)	27 (6.9%) / 362 (93.1%)	0.001
Alcohol consumption (Yes/No)	69 (25.3%) / 203 (74.7%)	204 (52.4%) / 185 (47.6%)	0.001
Regular physical exercise (Yes/No)	76 (27.9%) / 196 (72.1%)	172 (44.2%) / 217 (55.8%)	0.002
Currently married (Yes/No)	257 (94.4%) / 15 (5.6%)	268 (68.8%) / 121 (31.2%)	0.001
Having children (Yes/No)	242 (89%) / 30 (11%)	321 (82.5%) / 68 (17.5%)	0.021
Living with a relative (Yes/No)	14 (5.1%) / 258 (94.9%)	46 (11.8%) / 343(88.2%)	0.014
Having a private room (Yes/No)	263 (96.7%) / 9 (3.3%)	376 (96.7%) / 13 (3.3%)	0.847
Total income (Male+ female) (n, %)			0.256
Low	95 (35%)	117 (30%)	
Middle	122 (44.9%)	175 (45%)	
High	55 (20.1%)	97 (25%)	
Education level (n, %)			0.001
Primary school	72 (26.5%)	27 (7.0%)	
Middle school	18 (6.6%)	19 (4.9%)	
High school	99 (36.4%)	64 (16.4%)	
University	73 (26.8%)	266 (68.4%)	
Master's degree	10 (3.7%)	11 (2.8%)	
Doctorate	0	2 (0.5%)	

Table 3. Multivariate Logistic Regression Analysis of Factors Associated with the Presence of PE in Men

Predictor Variable	β	p-value	Odds Ratio (OR)	95% CI for OR (Lower–Upper)
Age (year)	0.055	0.001	1.057	1.039 – 1.075
Lack of regular exercise (Ref: Yes)	0.565	0.013	1.759	1.126 – 2.749
Education $\leq$ High School (Ref: $\geq$ Univ.)	0.799	0.001	2.224	1.413 – 3.501
Constant	– 2.826	<0.001	0.059	–

Table 4. Multivariate Logistic Regression Analysis of Female Partners According to the Presence of PE in their Male Partners

Predictor Variable	β (Beta)	p-value	Odds Ratio (OR)	95% CI for OR (Lower–Upper)
Age (year)	0.04	0.001	1.04	1.016 – 1.066
Comorbidity (Ref: No)	0.97	0.006	2.639	1.312 – 5.307
Lack of exercise (Ref: Yes)	0.783	0.004	2.188	1.284 – 3.73
Education $\leq$ High School (Ref: $\geq$ Univ.)	–1.097	<0.001	2.995	1.778 – 5.044
Constant	–2.071	<0.001	0.126	–

Table-5. Comparison of GRISS and SRPS Scores Between Women with and without a Partner with PE

	Women with a PE partner	Women without a PE partner	p value
Sexual Frequency* (median, IQR)	3 (2-4)	4 (3-6)	0.001
Communication* (median, IQR)	2 (2-4)	4 (3-6)	0.001
Avoidance* (median, IQR)	2 (2-5.5)	5 (2-7)	0.001
Touch* (median, IQR)	3 (1-5)	4 (3-6)	0.001
Satisfaction* (median, IQR)	4 (3-7)	6 (4-8)	0.001
Vaginismus* (median, IQR)	5 (4-7)	6 (4-8)	0.127
Anorgasmia* (median, IQR)	5 (3-7)	7 (5-9)	0.001
Quality* (median, IQR)	5 (3-6)	6 (4-8)	0.001
Relationship control ^W (median, IQR)	3.27 (2.87-3.60)	3 (2.60-3.33)	0.001
Decision-making dominance ^W (median, IQR)	2.50 (2.50-2.50)	2.50 (2.13-2.50)	0.054
Overall score of SRPS ^W (median, IQR)	3.07 (2.77-3.36)	2.92 (2.48-3.21)	0.001

*GRISS: Golombok–Rust Inventory of Sexual Satisfaction, ^WSRPS: Sexual Relationship PowerScale

Figures

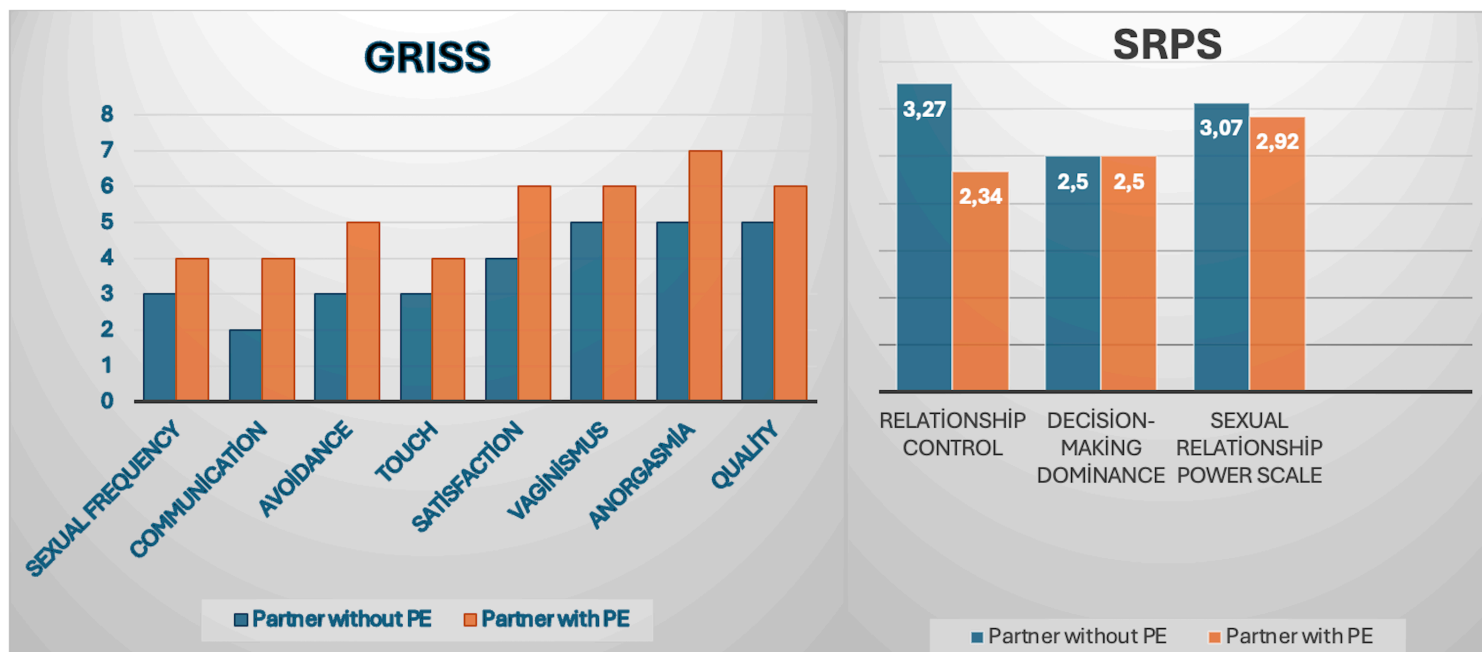


Figure 1

Comparison of GRISS subscale scores and SRPS scores between women with and without a partner with premature ejaculation. **GRISS: Golombok–Rust Inventory of Sexual Satisfaction, SRPS: Sexual Relationship PowerScale

Factors Influencing Premature Ejaculation: A Comparative Analysis of Male and Female Partner Data

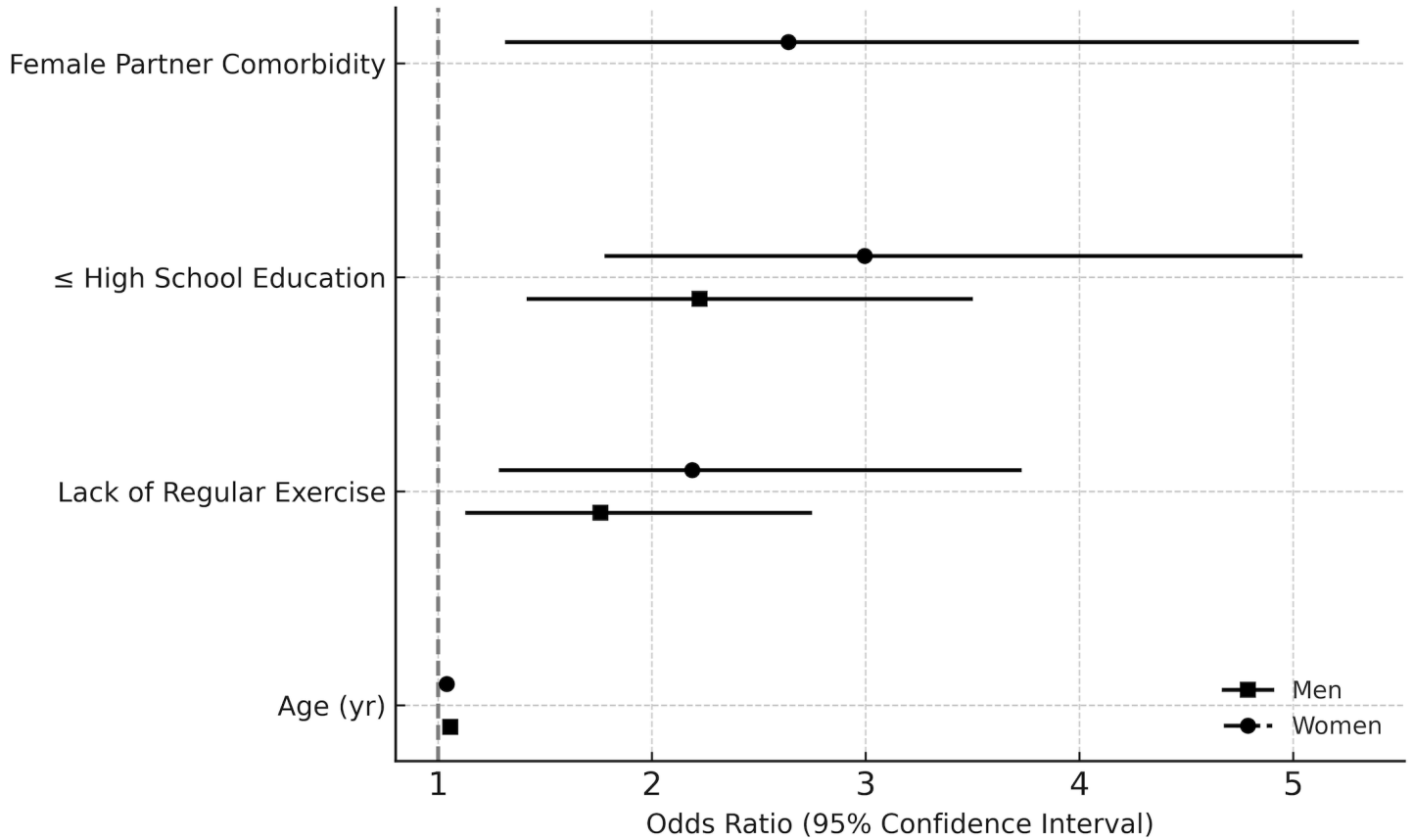


Figure 2

Forest plot illustrating the multivariate logistic regression results for both male and female cohorts, summarizing the independent predictors and their adjusted odds ratios