‘A loose nerve’: Culture(s), Time and Governmentality in the biomedical treatment of Premature Ejaculation in Bangladeshi Muslim men

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A PhD thesis

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Declaration

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged giving explicit references. A reference list is appended.

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Nothing exists in isolation (Chinese proverb)

Abstract

Introduction: premature ejaculation (PE) is a common sexual dysfunction. Current explanations of PE are homogenised and culture-free. These explanations do not resonate with the local Bangladeshi Muslim male population, who over-represent attendees in the local clinic.

Research question: What are the factors that form Bangladeshi Muslim men's knowledge(s) of premature ejaculation?

Design: this is a first level exploratory research project using thematic analysis of semi-structured responses gained during a randomised trial comparing two biomedical interventions followed by a modified behavioural therapy. Foucault's concept of governmentality was the theoretical foundation of the research.

Results: three themes were dominant in explaining PE both in the participant narratives and the published literature. These themes were biomedical, psychological and cultural. Medicine, through disciplinary practices, positions patients in certain spaces through the use of surveillance and panopticism. Participants in the trial both occupied and rebelled against this positioning, creating tensions and contradictions between meanings of PE and clinical practice that are in marked contrast to the recommendations of biomedical literature. Motivation for seeking treatment was changes in ejaculatory recovery, and the main motivator was the man's partner. There was little or no intimacy in Bangladeshi Muslim men that exacerbated PE.

Conclusions: biomedical discourses seek to reduce sexual activity into a time-focussed goal rather than a mutually enjoyable activity. Participants in the research also reduced sexual activity to a time goal, but separated mind from body, possibly due to sexual inexperience and possibly due to cultural pressures. Sex education was minimal or absent, which explains pressures to perform, disengagement from behavioural therapy and demands for pharmacological therapies. This research has discovered new knowledge that leads to an increased understanding of PE in Bangladeshi Muslim men.

Chapter 1

Introduction

Premature ejaculation (PE) is defined as persistent or recurrent ejaculation with minimal stimulation that causes marked interpersonal distress; the estimated prevalence is 22.7% (Porst, et al. 2007). The definition is drawn from the American Psychiatric Association (1994), indicating that psychological and biomedical discourses form the diagnostic criteria for PE. Prevalence data is drawn from Internet studies where men are willing to record their experiences of sexual activity. Thus, three discourses form knowledge of PE; psychological, biomedical and personal. These knowledges are drawn from diverse sources. Recently, biomedical reports indicate that 'no major cultural differences exist between US and EU men' (Giuliano, et al. 2008; 1048), but this statement does not resonate with local clinical experience, where Bangladeshi Muslim men over-represent the number of men presenting with PE, and where there are strong health beliefs related to causation (and acceptable treatments).

The research explicated in this thesis explores cultural meanings of PE in Bangladeshi Muslim men and examines how medicalisation constructs knowledge of PE. In addition, how knowledge is colluded with, via socialisation, is also discussed.

Research question and aims:

The primary research question driving this research is: What are the factors that form Bangladeshi Muslim men's knowledge(s) of premature ejaculation? Aims associated with this question are:

- What are the norms of sexual activity in Bangladeshi Muslim men with PE?
- What are the barriers to discussing sexual activity and engaging in treatments for PE?
- How do Bangladeshi Muslim men construct knowledge of PE?

In addressing these aims, only data from participants in the research were used, and thus the results only represent those men motivated (or desperate) enough to consent to participation in the research. The data cannot be extrapolated to Bangladeshi Muslim men in general.

Premature ejaculation is not culture-free

Giuliano, et al's (2008) contention, shared by other researchers, positions men as a homogenous group where sexual experience (and all of the cultural learning associated with sexual activity) is excluded from the meanings of each sexual encounter. The thoughts and experiences of the man's partner are also often missing from the body of knowledge that constructs the corpus of knowledge about PE.

Knowledge of PE is drawn from clinical (biomedical) practice, which is the only legitimate and socially acceptable location for discussion of a sexual dysfunction with a third party. The clinic is the social space where hitherto private knowledge (of sexual activity) is revealed. This private knowledge is recorded, and over time, norms or assumptions about sexual activity become known. Subsequently, the normal ejaculatory latency time (ELT) becomes known (estimated to be between 3-7 minutes) and is the measure by which dysfunction is established. The premature ejaculator consequently becomes visible by definition of his short latency. The clinic, then, is the point of articulation between private practices and social (biomedical) knowledge.

Underpinning this social (biomedical) knowledge are the learnt and taken-for-granted social messages; those social norms that are internalised and reinforced through expected behaviours. Examples of social norms related to sexual activity are found in most religious texts. In Islam, marriage is seen as 'the fortress that protects people from being lured into immoral ways by their passionate urges' (Maqsood, 2006; 164). For Muslims, illicit sexual activity (zinah) is forbidden (haram). Consequently, marriage is considered to be

protection from inappropriate sexual activity, and serves to illustrate how a social convention confers norms of behaviour on a population.

This research explores the phenomenon of the biomedical clinic and the expected norms of sexual behaviour, by using the conceptual framework outlined by Foucault. Foucault offers insights into governmentality, what is referred to as the conduct of conduct, which means how individuals come to know that they have a problem, and how they come to learn where to go to solve it (which is the moral imperative of health).

Foucault utilises a concept that he terms problematisations, which are ways of exploring particular phenomena. In the History of Sexuality (1979), Foucault explored the paradigmatic shift from sexual activity as an art (Ars Erotica), where knowledge/truth is drawn from pleasure, to sexual activity as a science (Scientia Sexualis), where the truth of sex is geared to a form of knowledge-power. Using Foucault's concepts PE becomes scientifically known by virtue of the medical clinic.

Knowledge drawn from clinical practice does not solely formulate the phenomena of PE. Other discourses are added to the corpus of knowledge about PE and include; definition; time; culture; and terminology. These discourses (refer to figure 1) coalesce into the knowledge of PE, and these are explored through problem spaces. Problem spaces are drawn from particular domains of power, and consequently are essential to explore to understand the meanings of PE in Bangladeshi Muslim men.

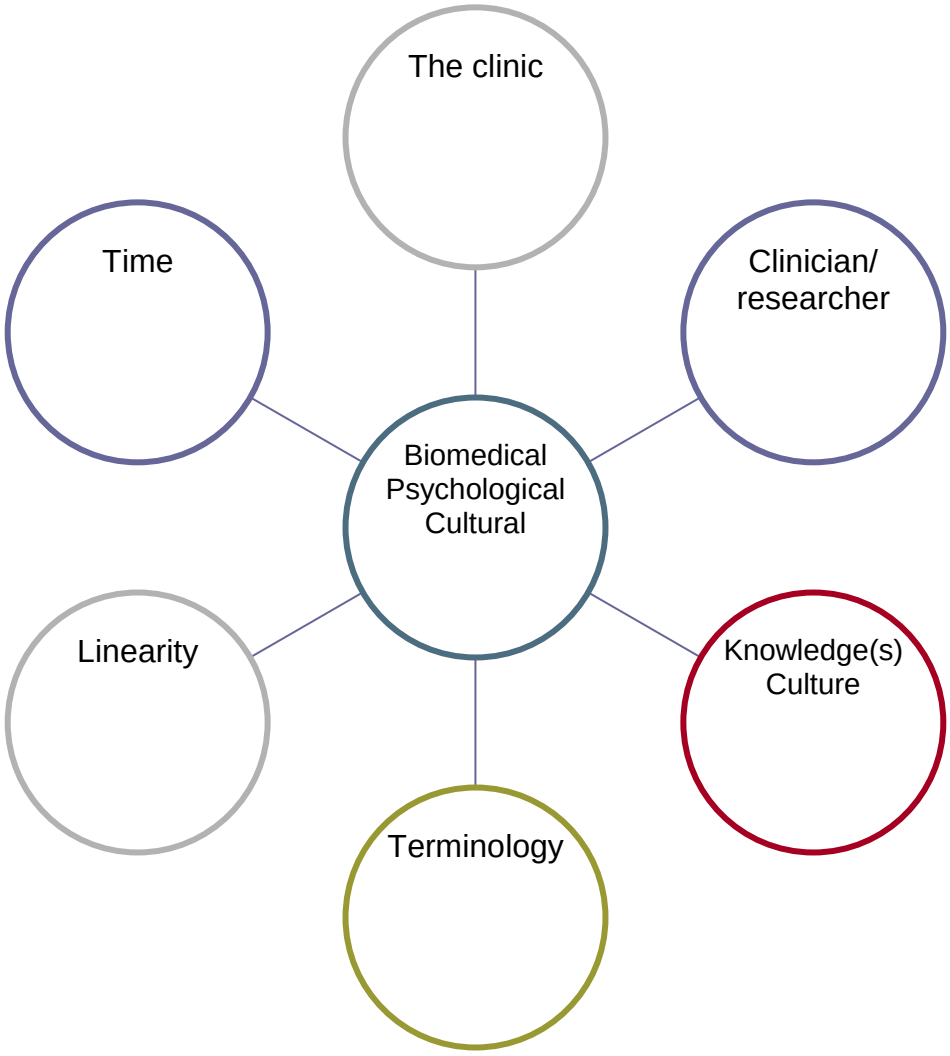


Figure 1 Problem spaces

The approach used in this research (using Foucault as a conceptual framework) and undertaking research in a Bangladeshi Muslim male population in East London have not been undertaken before. The findings of this research contribute new knowledge to understanding PE. This new knowledge is described on pages 22 – 23.

Why Bangladeshi Muslim men?

The majority of men attending the local clinic with PE were from Bangladesh (80%) and of the Muslim faith (80%), which is in contrast to those seeking treatment for ED, where less than 30% of men are Bangladeshi Muslim men.

In the 2001 Census the three most reported groups in East London (Tower Hamlets), in which the clinic is situated, were White, Bangladeshi and Afro-Caribbean. The most commonly reported religions for Tower Hamlets were Christian and Muslim, and the mean age of the population was 31.85 years (http://neighbourhood.statistics.gov.uk). (refer to tables 1.1, 1.2, 1.3 and 1.4)

Table 1.1 Recorded Ethnicity (Office for National Statistics, 2001)

	Tower Hamlets	**London**	**England**
White	42%	59%	87%
Bangladeshi	33%	2%	0.5%
Black African/Caribbean	6.02%	10.07%	2.11%
Indian	1.53%	6.09%	2.09%
Pakistani	0.76%	1.99%	1.44%

Table 1.2 Self-reported Religion (Office for National Statistics, 2001)

	Tower Hamlets	**London**	**England**
Christian	38%	58.23%	71.74%
Muslim	36%	8.46%	3.10%
None	14%	15.76%	14.59%

Table 1.3 Mean and median age of population (Office for National Statistics, 2001)

	Tower Hamlets	**London**	**England**
Mean age	31.85	35.95	38.60
Median age	29	34	37

Table 1.4 Population and employment data (Office for National Statistics, 2001)

	Tower Hamlets	**London**	**England**
18-24 year olds	25,000	721,200,	4,706,200
25-49 year olds	102,300	3,234,300	17,957,500
50-64 year old men/50-59 year old women	16,700	903,600	7,640,400
Employment rate	54.6%	69.3%	74.3%
Unemployment rate	13.2%	7.6%	5.5%

There are significant health inequalities in East London, which led to the speculation that certain groups were experiencing greater levels of concern in meeting expected norms of sexual activity. These norms influenced help-seeking, and treatment-engaging, behaviours.

Published literature does not concern itself with culture or cultural taboos when developing an understanding of PE. There are four domains of knowledge that have been identified in the review undertaken for this research. These are prevalence; aetiology, definition and treatment. Each domain of knowledge has been analysed, and results from this research indicate that definitions of PE are becoming increasingly medicalised, and that differential features of PE (lifelong or acquired) are not easily applied to Bangladeshi men because of the taboos concerning pre-marital sexual activities (whether masturbation or intercourse). The discussion and analysis of the literature serves to introduce the philosophy that was used to view and interpret the results (Foucault). (Refer to chapter three).

Foucault's concept of Governmentality has facilitated power relationships to be uncovered. In addition to the disciplinary power exerted by medicine and psychology, this research has identified that for most of the participants, the power behind help-seeking behaviours was the man's partner, who was unsatisfied with the sexual relationship, and not the man. The disciplinary power relationships, whilst located in the clinic, are expected to extend beyond this space, into the private space of the patient's home. This research has shown that Bangladeshi Muslim men come to understand PE through the displeasure of their wives and are threatened with divorce/separation before men seek help; particularly if social norms (usually production of children) have not been met. This knowledge is new, and contributes to the corpus of knowledge about PE, specifically why Bangladeshi Muslim men over-represent the clinic. Additionally, the research identified acceptable and unacceptable sexual practices, which shed some important insights into why these men are reluctant to engage in behavioural therapies for treatment.

The methodology used in this research was quantitative and qualitative using a randomised control trial (RCT) and interviews. Men who signed informed consent were enrolled into the research and randomised to receive either paroxetine 20mg daily for two months, then a behavioural therapy programme that did not require masturbation, or Premjact Spray (a lidocaine-based spray applied to the frenulum 10 minutes before intercourse), then the behavioural therapy programme that did not require masturbation. The results of the randomised trial (refer to Steggall, et al. 2008) are not the primary focus of this thesis; it is the responses to the semi-structured interviews that form this thesis. Thematic analysis, which has not been used before in research concerning PE, allowed the components of power as they concern Bangladeshi men, to emerge. The components are biomedical, psychological and cultural, which are the over-arching themes. Each component theme has sub-themes which are definition; time; treatment; norms; partner; and person. These components have not been articulated previously. Each impacts on the understanding that Bangladeshi men have concerning PE. This discernment of new knowledge informs clinical practice.

The results of this research show that the mean self-assessed ELT was 46 seconds and mean stopwatch-assessed ELT was 79 seconds. The main motivator for seeking treatment was not ejaculatory latency, but pressure from the partner when the post ejaculatory recovery time (PERT) had lengthened. The mean duration of PE was 6-10 years. Causation of PE was always attributed to physical and not relationship factors. Commonly PE was understood as a consequence of weak blood, loose nerves, or masturbation. Furthermore, there was no agreement between the man and his partner about the need for the conditions of sex to be met, for example, trust or intimacy without intercourse. For some relationships the only intimacy that occurred with the partner was during intercourse, which increased pressure to perform. Although this pressure to perform was present early on in the relationship, the research identified that sex education was absent and for many it was a forbidden subject for discussion. Foreplay commonly lasted for only 5 – 10 minutes, and for several participants, they did not know what this was or indeed that it was needed. Some of the narratives related to foreplay were

'*When I want sex I just tell her and start*'. These findings are of clinical relevance in that they explain a) the motivation for treatment, b) why such men disengage from behavioural treatment; c) why there is a high demand for pharmacological intervention; and d) why treatment regimens may fail or take longer in this cultural group.

These findings are explored further in the Discussion Chapter, particularly as they relate to the disciplinary domains of knowledge identified in the review of the literature. The discussion uses two means for exploring the results. The first is problem spaces, which categorise the results and the second is how the main component themes (biomedical, psychological and cultural) are articulated by governmentality and biopower.

This research therefore contributes to the corpus of knowledge about PE in several ways. Use of Foucault's Governmentality and exploration of Biopower (which has not been used previously in research into PE) articulate where power operates (the clinic and in the man's partner), and this knowledge serves as a means for viewing the main results of the research. Thematic analysis, which has also not been used in research into PE, exposed the core domains of knowledge of PE, biomedical, psychological and cultural, all of which coalesce (at least in the patient) when they internalise the experience of the condition. The results have contributed to new ways of working (a change in clinical management) and to the development of an education programme within the local Bangladeshi population, whereby health guides have received training and now give talks raising awareness of the condition, but more importantly, of what normal sexual activity entails (communication) and where to seek help.

Summary

This chapter has outlined the purpose of the research, research question and aims. It has identified that PE is a complex and contradictory condition; one that bothers local Bangladeshi Muslim men more than any other cultural group. The research explicated in this thesis identifies why these men appear

more bothered with the condition than others' and this knowledge serves to inform clinical practice. The philosophical framework used is that of Foucault, which has hitherto not been used in this area of clinical practice. The research participants are Bangladeshi Muslim men, who traditionally do not form part of the corpus of knowledge concerning PE. This thesis explicates new knowledge into the cultural expectations that exist for these participants. The next chapter articulates a review of the literature and identification of the domains of knowledge that contribute to understanding PE.

Chapter 2

A review of the literature

Introduction

Premature, early or rapid ejaculation, are all terms used to describe the event where men are unable to control ejaculation during sexual arousal and/or activity. For the purposes of this thesis, the acronym PE will be used throughout. PE is thought to be the most common sexual dysfunction in sexually active men, with an estimated prevalence, based on Internet surveys, clinical experience and published reports, of up to 22.7% (Porst, et al. 2007). This prevalence is far higher than that of erectile dysfunction (ED) or any other reported sexual dysfunction. A precise definition of PE has yet to be formulated, and both definitions are presented, although for the purposes of the study, the American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, edition four (DSM-IV) was used, and an additional stop-watch dependent measure of ejaculatory time of less than 3 minutes included.

The most common treatment options for PE are Behavioural therapies (after Masters and Johnson, 1970); local anaesthetics, for example Premjact Spray, Eutetic mixture of local anaesthetic (Emla) cream, Instillagel, or lidocaine cream; constriction bands; desensitising bands; and, perhaps most commonly used in contemporary clinical management, Selective Serotonin Re-uptake Inhibitors (SSRIs) or equivalent medication.

The intention in this section of the thesis is to review the main elements related to PE, specifically prevalence, definition, aetiological features, and finally, the treatment options. Although the data is presented as discrete subheadings, the reality is that there is considerable overlap in what the prevalence, aetiology, definition and treatments are. What has been

attempted here is a separation of key themes which illustrate the main discourses related to the clinical management of PE.

Methods

Using the keywords premature ejaculation, rapid ejaculation, early ejaculation, and treatments, the databases of Ovid, Medline, Embase and Google Scholar were explored. The initial search terms yielded 10,500 results, and therefore the key terms were adjusted and refocused on review papers, English language and journals published between 2000 and 2003 which coincided with the initial interest in the clinical management of PE as a result of a growing number of referrals to the ED clinic. By narrowing the search terms, a clearer understanding of the (then) current clinical management of PE was established. From this initial review, the search terms were re-examined and re-focussed on SSRIs, Lidocaine, Prevalence, Definition and Aetiology of PE. The final analysis of 140 clinical papers were predominantly from the disciplines of Medicine and Psychiatry/Psychology. The search was then repeated but focussed on journals specialising in Cultural and Sociological discourses. The results of these investigations indicated four main areas of tension (prevalence, definition, aetiology and treatment), and from three different perspectives, i.e. medicine, psychology and sociology. In a few cases, the literature contained elements of all three perspectives; but by far the most common perspective was medical.

Results

The results of the literature review have been presented in four domains, i.e. prevalence, aetiology, definition and treatment. The review of the literature continued throughout the duration of the research and therefore, some of the literature has been identified after the research was designed and begun. The ‘later’ literature has been included to illustrate the changes in the discourses over time, and also to illustrate the evolution in clinical management. What is meant here is that clinical management of PE, according to the published literature, has moved from behavioural therapies to SSRIs, but perhaps this

has only occurred in the literature and not in clinical practice. Subsequently, SSRIs may not be the solution that is perhaps hoped for. This approach further exemplifies the competing discourses that seem to own PE as their specific territory.

i) Prevalence

As indicated in the introduction, the latest prevalence estimate of PE has been given at 22.7% (Porst, et al. 2007) and this has remained relatively constant over the past 3 decades. Derogatis (1980) estimated PE to occur in 30% of all men, Cavallini (1995) cited PE as being the most common sexual disorder in men, whereas McMahon and Touma (1999) and Verma, et al. (1998) variously cite PE affecting 75-78% of men at some point in their lifetimes. Prior to the study by Porst, et al. (2007) the literature consistently cited a prevalence of 20-30% (Patrick, et al. 2005).

Data from Laumann, et al. (2005), from an international survey investigating the attitudes, behaviours, beliefs, and sexual satisfaction of 27,500 men and women aged 40-80 years, gave an indication of reported prevalence rates across various European regions and beyond. PE was the most commonly reported sexual dysfunction, with 31% of men from Southeast Asia reporting it (Laumann, et al. 2005). The overall prevalence of PE was listed as 20.7 % (Northern Europe); 21.5% (Southern Europe); 27.4% (Non-European West); 28.3% (Central/South America); 12.4% (Middle East); 29.1% (East Asia); and 30.5% (Southeast Asia), but of note is that East Asia and Southeast Asia did not include data from India, Pakistan or Bangladesh. Furthermore, although the study reports a negative correlation between education and reports of PE, participant's religion was not shown, rather 'belief in religion guiding sex' was asked. This question is not sufficiently sophisticated to capture the complexity of social expectations as they relate to sexual activity.

Epidemiological studies have sought to examine regional variations in prevalence, indicating 24% of American men, 20.3% in German men, and 20% in Italian men, reported PE in a large (n=12,133) Internet-based survey

(Porst, et al. 2007). Jannini and Lenzi (2005) also examined prevalence in different regions, identifying a prevalence of PE in Turkish men of 21%.

The extent to which these reported prevalence rates reflect the 'true' burden of PE are based only on men motivated to attend clinics, or who have access the Internet and who respond to surveys. These rates may not represent an accurate picture of the prevalence of this condition. Furthermore, self-reported measures of 'normal' ejaculatory times may well be over-estimated or under-estimated, particularly because ejaculation is seen as a tangible example of potency, power and masculinity.

The influence of cultural factors in admitting PE may affect the perception of ejaculatory dysfunction and could explain the presence of psychological PE (Jannini and Lenzi, 2005). A limited number of papers (Richardson and Goldmeier, 2005; Steggall, et al. 2006; Frewen, et al. 2007) have indicated a higher prevalence of PE in men from Muslim backgrounds. The explanation of this has yet to be elucidated, but Jannini and Lanzi (2005) speculate that in conservative Muslim societies PE may be due to frustration caused by later marriage, or it can be as a consequence of the guilt related to extramarital activity, masturbation or homosexuality (Jannini and Lenzi, 2005). Given the power associated with semen, and its relationship to masculinity and potency, prevalence rates should take into account the cultural meanings of sexual activity. Many of the published reports fail to acknowledge the cultural meanings of ejaculation, or of PE, which may further misrepresent the prevalence of the condition.

Sotomayor, et al. (2004) conclude that PE is an under-reported and under-treated condition, offering the opinion that "men with PE often feel stigmatised by the condition and embarrassed" which acts as a barrier to seeking help. Clearly not all individuals (and couples) feel that they have (or perhaps are not concerned with) PE; consequently it is only those who are bothered with the condition that seek advice. As Abdel-Hamid, et al. (2001: 42) contends "only men who are extremely motivated participate in clinical trials" and so the prevalence data presented should be interpreted with caution.

Summary of prevalence data

The prevalence of PE, based on a large Internet survey, is estimated to be 22.7% although the true estimate remains unknown because many men do not seek help for this condition. Morales (2007) asserted that only 9% of men affected by PE actually seek help. PE cannot be considered out of context. By this is meant that each man will have his own cultural expectations about normal sexual activity. These expectations will be merged with those of his partner(s)' cultural expectations, and overlaying both of these are the expectations from a wider society that place norms on sexual behaviour. These norms appear to be based on medical data, or specifically on medicalising sexual activity in order to classify, codify and objectify sexual activity and behaviours. The concept of medicalisation will be discussed later, along with the philosophy of Michel Foucault, but in essence the medical domain researchers are searching for a definable set of criteria in which to fix premature ejaculators. The observation by Jannini (2007) exemplifies this, and in his editorial comment to Porst, et al. (2007), he states that:

> "any attempt to 'medicalise' a symptom traditionally considered to be psychogenic (and thus under-diagnosed and under-treated) is more than welcome in sexual medicine" (Jannini, 2007: 1766)

ii) Aetiology

The causes of PE have been listed as masturbation; fear of the consequences of sexual activity; aberrant neuroconduction; and a combination of these. Whilst some of these causes may have been rejected by contemporary scientific understanding, the causes have become absorbed into lay understandings of PE and of their possible causes whether quasi-scientifically proven or not.

In 1717, John Marten was attributed as the author of 'Onania; or, The Heinous Sin of Self Pollution, and all its Frightful Consequences, in both SEXES Considered' (1717, cited in Laqueur, 2003). This pamphlet appeared in Coffee Houses and Public Houses, and offered an alleged cure for masturbation.

Boerhaave (1688-1738) developed the theme of the deleterious effects of masturbation, claiming the effects included lassitude, feebleness and weakening of motion. Tissot (1766) was attributed to making a link between non-procreative sexual activity and onanism, effectively generating an anxiety over inappropriate semen loss. Tissot cited ‘evidence’ of the effects of masturbation from observations of detainees released from mental institutions who frequently masturbated, believing masturbation caused strain on the nervous system, and ultimately, insanity. The claim from Tissot was that Onanism caused:

- Cloudiness of ideas and sometimes madness
- Decay of bodily powers, resulting in coughs, fevers and consumption
- Acute pains in the head
- Pimples on the face
- Impotence, premature ejaculation, gonorrhoea, priapism, bladder cancer and constipation.

Treatments for the habitual masturbator included orchidectomy, clitorroidectomy and even penectomy for severe offenders.

It would appear that masturbation and inappropriate semen loss have become ‘blurred’ and merged together when control of sexual practices are exercised. The power of semen is something that has concerned civilisations for centuries, and these observations related to semen seem to have been absorbed into the popular consciousness, particularly in relation to inappropriate semen loss (refer to table 2.1).

Table 2.1 The historical perspectives and development of beliefs about semen loss in some cultures. Adapted from Sumathipala, et al. (2004).

Authority	Period	Comments on semen loss
Susruta	Unknown	Semen is the most concentrated, perfect and powerful bodily substance. Its preservation guarantees health and longevity.
Aristotle	384-322 BC	'Sperms are the excretion of our food, or to put it more clearly, as the most perfect component of our food'
Galen	130-201 AD	Involuntary loss was termed 'gonorrhoea': 'it robs the body of its vital breath'; 'losing sperm amounts to losing the vital spirits'; exhaustion, weakness, dryness of the whole body, thinness, eyes growing hollow, are the resulting symptoms.
Marten	1716?	'Onanism or the heinous sin of self pollution explained in all its frightful consequences'
Tissot	1728-1797	'Losing one ounce of sperm is more debilitating than losing forty ounces of blood' reported in a treatise on the Diseases Produced by Onanism. His tenet was that debility, disease and death are the outcome of semen loss
Maudsley	1835-1918	Semen loss, especially if it occurs through masturbation, results in serious mental illness
Freud	1856 - 1939	'Neurasthenia in males is acquired at puberty and becomes manifest in the patient's twenties. Its source is masturbation, the frequency of which parallels that of neurasthenia'. Freud opposes Steckel's view that semen loss has no pernicious effect on brain function.

These beliefs about masturbation, particularly the damage to health and the 'semen-as-strength' health belief, continue to be known and cited as reasons why masturbation cannot be used in treatment for PE, particularly by Bangladeshi Muslim men.

Concerns over masturbation (and inappropriate semen loss) exist in many cultural groups; not just Bangladeshi Muslim men. For example Shimizu and Mizuta (1995) reported a case of autocastration in a 17-year old, non-psychiatric patient who mutilated his genitalia under clear consciousness because of a conflict over his frequent masturbation. Catalano, et al. (1996: 38) also reported autocastration, but in their example, a 22-year old man amputated his penis with a chain saw because 'he (the patient) was influenced by the popular media, which condemned masturbation'.

The historical context of the aetiology of PE is therefore anxiety over masturbation and inappropriate semen loss. Kinsey (1960) and Masters and Johnson (1970) attributed causes of premature ejaculation to be hurried intercourse, resulting in 'faulty learning' which lead to PE during relationships (refer to Kinsey Institute and Masters and Johnson). Alternative theories for causation of PE are hidden female arousal difficulties (Levine, 1975), and combined factors, such as organic (for example, prostatitis, urethritis), psychological, interpersonal factors and also lay beliefs (Lee, 1995). Kindler, et al. (1997) introduced 'performance anxiety' to these combined factors. Recent aetiological features have focussed on penile hypersensitivity and hyperexcitability (Xin, et al. 1997; Ozcan, et al. 2001; Yilmaz, et al. 2002).

Yilmaz, et al. (1999) postulated that ejaculatory control was governed by three linking neural processes; modular influence from the supraspinal level; interaction at the spinal cord level; and amplitude of the sacral reflex, suggesting that serotonin inhibits sexual activity. However, the role of penile hypersensitivity is debatable (Paick, et al. 1998), although current contemporary literature remains focussed on physical causes, particularly those of a neurobiology nature. Waldinger, et al. (1997) suggested that ejaculation is peripherally activated by alpha 1 sympathetic nerve stimulation, and went on to suggest use of Paroxetine hydrochloride as an effective mediator in delaying ejaculation since Paroxetine has no sympathiocolytic side effects. Various animal studies were initially used to support this contention.

Alternative themes for aetiological causes include psychological, urological, hormonal, or neurologic factors being postulated as either primary or contributory/additive roles (Screponi, et al 2001). Studies by Rowland and Slob (1992) suggest penile hypersensitivity evidenced by perception of minute vibratory stimuli, but this hypersensitivity, appears confined to penile skin only. Differential features in diagnosing premature ejaculation are:

- Onset or duration: whether life-long or acquired (episodic)
- Context or range: whether generalised (global or all situations) or situational (some but not all cases).

Metz and Prior (2000) provided a summary of the types of PE based on known or hypothesised causes listed in research reports (refer to table 2.2).

Table 2.2 Summary of the types of PE based on known or hypothesised causes listed in research reports Adapted from Metz and Prior (2000)

Type	Premature ejaculation onset	Premature ejaculation context	Clinically observed frequency
Physiological			
Neurologic constitution (innate biological predisposition to ejaculate quickly)	Lifelong	Generalised	Very common
Physical illness (e.g. prostatitis, Urinary tract infection, etc,)	Acquired	Generalised	Occasional
Physical injury (e.g. spinal cord injury)	Acquired	Generalised	Rare
Pharmacological side effect (e.g. withdrawal from opiates)	Acquired	Generalised	Rare
Psychogenic	Acquired	Generalised or situational with partner	Common
Psychological	Lifelong	Generalised or situational	Very common
Constitution (chronic individual psychological disorders, e.g. obsessive-compulsive disorders, etc.)			
Psychological distress (e.g. reactive depression, unresolved emotional relationship conflicts)	Acquired	Generalised or situational	Common
Psychosexual skills deficit (lack of sexual experience and skill, difficulty focussing on own sensations)	Acquired	Generalised or situational	Common
Concomitant premature ejaculation with another sexual dysfunction (e.g. erectile dysfunction)	Acquired or lifelong	Generalised or situational	Common

In 2004 Waldinger contended that, by using the principles of evidence-based medicine, there was little evidence to support psychological explanations for PE. The alternative proposition was that PE was related to diminished

serotonergic neurotransmission, a 5-hydroxytryptamine $(HT)_{2C}$ receptor (5-HT_{2C}) hyposensitivity and/or 5-HT_{1A} receptor hypersensitivity (Waldinger, 2004).

Waldinger (2002) and Waldinger and Olivier (2000) proposed a threshold for intravaginal ejaculatory latency time or IELT, where a low threshold indicated that only minimal sexual arousal was needed before ejaculation. The low threshold was assumed to be associated with low 5-HT neurotransmission and possible hypofunction of the 5-HT_{2C} receptor and/or a hyperfunction of the 5-HT_{1A} receptor. Waldinger (2002) found that in men with greater ejaculatory control, 5-HT neurotransmission varied around a normal or average level and the 5-HT_{2C} receptor functions normally. These men had the neurobiological ability to voluntarily decide to ejaculate quickly or after a longer duration of intercourse, but if threshold was high or very high, then men had difficulty in ejaculating (Waldinger, 2002).

Waldinger, et al. (2004) formulated a new theory of the cause and genesis of lifelong PE, postulating that lifelong premature ejaculation is not an acquired disorder caused by initial hurried intercourse, as suggested by Masters and Johnson, but is part of a normal biological variability of IELT in men, with a possible familial genetic vulnerability (Waldinger, 2002; Waldinger, et al. 1998; Waldinger and Oliver, 2000). In 2004 Waldinger attempted to develop the theory of a genetic basis for PE, endeavouring to elicit whether patients' fathers also had PE, but he had limited success in gaining accurate data. Recently the genetic basis of PE has been further investigated by Jern, et al. (2009). They found a significant genetic effect in their study of Finnish men, leading them to conclude that there was a moderate (28%) genetic effect on PE, with some environmental effects impacting on the individual. Whilst the data is drawn from Finnish men, there may be a similar findings in Bangladeshi men, particularly since Bangladeshi (and other South Asian men) tend to only marry from the home country which does not dilute the gene pool (refer to Eaaswarkhanth, et al. 2009).

However, despite the contention from Waldinger (2004) for a neurobiological or neuroendocrine basis for PE, or examining Screponi, et al's (2001) contention that urological factors influence PE, the *perception* of sex and its effect on the *relationship*(s) must be considered (Jannini and Lenzi, 2005).

Rowland and Stewart (2005) suggest that Waldinger's (2002) contention for a neurobiological cause of PE is both correct but also misleading. It is correct because it could be a neurobiologic process, but misleading because it suggests that psychologic constructs are not critically important to understanding and treating the dysfunction. Rowland and Stewart (2005) go on to indicate that although a man can actively learn to attenuate his arousal, he can do little to alter his serotonergic activity either directly or via pharmacological inhibition. Rowland and Stewart (2005:34) conclude by stating that these distinctions are important 'because treatments are sometimes (although not always) based on presumed causes of disorders'.

Although evaluating PE using a taxonomy of organic or neurobiologic factors is attractive, it is reductive and limits the inclusion of the contribution that socio-cultural factors have, as indicated by Rowland and Stewart (2005). The literature indicates that four domains of uncertainty i.e. organic, psychological, relational, and socio-cultural, coexist in patients with PE, which (Jannini and Lenzi, 2005) suggests, are interdependent factors.

Thus the distinction between psychosocial (or psychodynamic) and organic (or medical) causes (refer to table 2.3) have the consequences that psychological PE should be treated by a psycho-sexologist, while organic PE must be cured by an andrologist. Nevertheless, as Jannini and Lenzi (2005: 401) conclude "this division into these mutually exclusive groups is not only inappropriate in most cases but also based on inadequate epidemiological grounds".

Table 2.3 The five pathogenic causes of PE (from Jannini et al. 2006)

Mechanism of action	Aetiology
Psycho-relational	Anxiety, relational problems
Neurobiological	Serotonin hyperactivity, penile hypersensitivity
Urological	Prostatitis
Hormonal	Hyperthyroid
Andrological	Erectile dysfunction

Recently, there has become a rejoining of PE as a neurobiological **and** a psychological/psychosocial problem, in that Waldinger (2004) believes that lifelong or primary PE may also lead to psychological distress, which is dependent on intra- and inter-personal factors, as well as cultural factors.

Waldinger (2007) has proposed a new classification of PE into a syndrome rather than a pathology or disease, incorporating the four types of the complaint, which are Lifelong PE; Acquired PE; natural-variable PE; and premature-like ejaculatory dysfunction (summarised along with treatment recommendations in table 2.4).

Table 2.4 Different types of PE postulated by Waldinger, 2007

Lifelong PE	Acquired PE	Natural variable PE	Premature-like ejaculatory dysfunction
Neurobiological Genetic	Medical Somatic	Normal variation	Psychological
Medication	Psychotherapy	Reassurance and psycho-education	Psychotherapy

Although this classification of PE into a syndrome may be clinically useful as a framework to guide management, there remains an assumption that there is a normal (timed) ejaculatory latency; in essence, diagnosis is achieved by a measuring IELT, rather than accepting the man's subjective experience of his symptoms. Furthermore, the explicit assumption is that men will engage in psychotherapy, and that psychotherapy confers a successful outcome after treatment; neither of which are borne out by clinical practice or a review of the literature. Sotomayor (2005) and Symonds, et al. (2003) identified that men with PE perceived themselves as having little or no control over ejaculation,

which is mirrored in diminished satisfaction with sexual activity. Satisfaction with sexual activity, coupled with cultural meanings of PE, remain important in understanding some of the aetiological features of PE. Four papers have reported that men from Muslim/Asian backgrounds are more likely to present with PE than men born in Western regions (see Nicolosi, et al. 2005; Richardson and Goldmeier, 2005; Steggall, et al. 2006; and Frewen, et al. 2007). The 'burden' of PE is therefore emotional and physical, and these should be considered in clinical management, as Lue, et al. (2004: 19) conclude 'the causes of PE remain uncertain and 'most likely include a combination of organic and psychogenic factors'.

Summary of aetiology

The aetiology of PE is poorly understood. Initial theories were rooted in interpretations from religious texts (for example Genesis 38:8-11 and Onanism), probably for commercial ends rather than an attempt to provide any insights into causation. From these early beginnings both psychiatry and medicine have attempted to codify, classify and stratify PE. The Twentieth Century introduced a move from psychological discourses that explained the causes of PE from mental characteristics to behavioural changes, to medical discourses that examined physiological parameters and causes for PE. Currently there are two discourses, psychology and medicine, which share a rocky marriage in elucidating the aetiology of PE, as exemplified by Rowland and Stewart's (2005: 31) observations that

> "to argue that PE is primarily a neurobiologic process (Waldinger, 2002) is correct but also misleading, correct because it could be nothing other than a neurobiologic process, misleading because it suggests that psychologic constructs used to describe the soft-wired processes are not critically important to understanding and treating the dysfunction."

Whilst these perspectives provide some pieces of the jigsaw for PE, observations of the cultural aspects of sexuality are absent. Sungar (1999)

identified that cultural factors influenced the presentation of sexual problems, their clinical management and the help-seeking behaviour of individuals and couples. What behaviours (including sexual ones) will be accepted or tolerated and their associated problems (for example, PE) with them are not culture-free (Segall, et al. 1990; Sungur, 1994; de Silva and Rodrigo, 1995).

Furthermore, if the contention from Abdel-Hamid, et al. (2001) is correct, and only those most bothered with PE will seek help, then only those most bothered will be the group from which aetiological information is drawn. Thus, if the observations from Nicolosi, et al. (2005), Richardson and Goldmeier (2005), Steggall, et al. (2006), and Frewen, et al. (2007) are accurate, then the aetiological features are based on 9% of men bothered with PE, of which between 60 and 90% are from Islamic/Central Asian/Middle Eastern countries. In which case, the culturally accepted norms of sexual activity, of procreation, or of acceptable treatments, must be considered in the clinical management of PE.

iii) Definition

There are currently two definitions used in clinical practice to define and diagnose PE. These are the Diagnostic and Statistical Manual 4th edition (DSM-IV) from the American Psychological Association (1994) (refer to table 2.5) and the International Statistical Classification of Disease and Related Health Problems, 10th Revision, (ICD-10; section F52.4). Prior to these definitions, the Masters and Johnson (1970) definition of PE, i.e. the inability of a man to delay ejaculation until his partner was sexually satisfied in at least 50% of encounters, was commonly used.

The American Psychiatric Association (1994) definition has three main criteria but no specific inclusion of time whereas the ICD-10 definition uses a measure of time to qualify the condition. The length of time between intromission and ejaculation has not be universally agreed: Screponi, et al. (2001) suggest less than 2 minutes should be used, as does Lue, et al. (2004) whereas Waldinger (2004) suggests that severe PE is an ELT of less than 1

minute. A consensus statement has added a measure of time (intravaginal ejaculatory latency time) of less than 1 minute, to the criteria used by the American Psychiatric Association (Lue, et al. 2004).

Table 2.5. DSM-IV criteria for premature ejaculation (American Psychiatric Association, 1994)

Criterion	Condition
A	Persistent or recurrent ejaculation with minimal sexual stimulation before, on or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect the duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.
B	The disturbance causes a marked distress or interpersonal difficulty.
C	Premature ejaculation is not exclusively the result of the direct effects of a substance (e.g. withdrawal of opioids).

Waldinger (2004: 202) argued that the scientific basis for the DSM-IV criterion is lacking, stating that 'persistent, recurrent, minimal stimulation and shortly after' are all vague and therefore need qualification. The proposal from Waldinger (2004) is a definition of PE which uses Intravaginal Ejaculatory Time (IELT) defined as the start of vaginal intromission to the start of intravaginal ejaculation, but this assumes a 'normal' site of intercourse (vaginal).

The ICD-10 (1994) defines premature ejaculation as: 'an inability to delay ejaculation sufficiently to enjoy lovemaking, manifest as either of the following: (1) occurrence of ejaculation before or very soon after the beginning of intercourse (if a time limit is required: before or within 15 seconds of the beginning of intercourse); (2) ejaculation occurs in the absence of sufficient erection to make intercourse possible: and the problem is not the result of prolonged abstinence from sexual activity' (International Statistical Classification of Disease and Related Health Problems, 10th Revision, ICD-10). The difficulty with these definitions remains a lack of a clear definition of what minimal sexual stimulation is, and what does 'shortly after' mean? (Astbury-Ward, 2002). Furthermore, these definitions lack a clear consensus of what constitutes *normal* ejaculatory latency, and how it can be measured

accurately. Normal ejaculatory latency has been suggested by Jannini, et al (2006) as being between 1 and 7 minutes after vaginal penetration, and thus PE is defined at any time less than this range. Rowland, et al (1993b) contends that the normal ejaculatory range is 1 to 12 minutes after the start of coitus, with the median ejaculatory latency of 7-9 minutes. Sotomayor (2005) indicates that estimated ejaculatory latency is between 6 and 13 minutes. Non-time definitions have used the number penile thrusts to define PE, and Althof (2004) indicates that less than 8 to 15 thrusts are the criteria for diagnosing PE. Most contemporary literature include measures of time as part of the diagnosis of PE, although by no means is this a universal practice, nor is deployment of an objective measure (usually a stopwatch) of ejaculatory time without its critics.

McMahon, et al. (2004) agrees that 'studies of rapid (premature) ejaculation are hampered by a lack of consensus as to what constitutes the dysfunction or even what to call it (i.e. early, premature or rapid ejaculation)' and furthermore the operational variables, such as voluntary control, distress, etc. have yet to be defined or agreed upon.

There appears to be a separation between scientific definitions of PE, which are used to standardise and objectify PE, and the patients own definition, and the consequences of PE. Waldinger (2004) contends that based on a trial of 110 men with lifelong PE, 90% ejaculated within 1 minute of vaginal intromission, of which 80% ejaculated within 30 seconds and 60% ejaculated within 15 seconds. Based on previous findings, Waldinger, et al. (1998) empirically defined PE as an ejaculatory latency of less than 1 minute, and went on to suggest that it is independent of psychological or relationship distress.

The literature is becoming focused on scientific knowledge, in the form of stopwatch IELT, rather than the man's own estimate of IELT or indeed his own level of distress that PE has caused. The question can be raised, What if the IELT is >3, 7, 9 or 12 minutes but the man and his partner are distressed? Is he denied all the treatment options for PE? As Althof (2004: 62) points out,

‘does a man warrant the diagnosis if he ejaculates in less than 30, 60, 90, 120, or 180 seconds after vaginal penetration?’ and what percentage of attempts of sexual activity are needed to evidence premature ejaculation? Furthermore, alternative types of sexual activity (anal or oral penetration) or same sex activity does not appear in the literature. Does ejaculatory time differ if non-vaginal penetration is enjoyed?

From reported studies on normal ejaculatory latency, wide variations between countries are evident. Data from the Multi Country Concept evaluation and assessment of PE incidence study, showing the perception of what constitutes a normal IELT, differs markedly between countries (refer to table 2.6).

Table 2.6. Estimated ejaculatory latency times (male and female) (Sotomayor, 2005)

Country (sample sizes)	**Estimated IELT (Minutes)**	
	Men	**Women**
USA (606♂, 300♀)	13.6	11.2
UK (315♂, 222♀)	9.9	8.5
Italy (304♂, 206♀)	9.6	8.6
France (301♂, 203♀)	9.3	8.4
Germany (328♂, 201♀)	6.9	7.4

In addition to a measure of time in the definition of PE, is the severity of the condition. The severity of the syndrome may be mild, moderate or severe, which may be clinically relevant, and may affect treatment recommendations (Cooper and Rowland, 2005) (refer to table 2.7).

Table 2.7 Severity of PE. Adapted from Cooper and Rowland (2005)

Severity of PE	Descriptor	Cognition
Mild	Frequency of occurrence of less than 50% of the time; estimated latencies greater than 1 or 2 minutes; a greater number of thrusts to ejaculation (e.g. more than 15)	Strong sense of control over ejaculation and limited performance anxiety
Moderate	Heightened sense of penile sensitivity, frequency of occurrence over 50%, estimated latencies of less than 1 minute,	Limited awareness of ejaculatory inevitability, and greater concern about the problem
Severe	High frequency of occurrence, the possible coexistence of ED, estimated latencies of 15 seconds or less, or even anteportal ejaculation	Greatly restricted sexual activity due to fear of failure; low intensity of somatic contractions and semen expulsion

A cultural dimension can be added to the definitions of PE. Jannini and Lenzi (2005: 402) conclude that PE is 'a culture-dependent symptom that is self-identified, self-reported, and self-rated with respect to severity'. PE is recognised in Asian (Indian) males as Dhat syndrome (Gupta, 1994). There are associated psychosomatic symptoms such as depression, sleeplessness, generalised weakness, thin and watery semen and various urinary complaints (Gupta, 1999).

Semen is considered a precious substance in Indian Cultures and some of the Indian names for semen are dhatu (metal or base substance) and mani (jewel) (Gupta, 1999). Atharva-ved, one of the ancient Indian religious books, mentions that a hundred drops of blood are required to make one drop of semen. Its loss is inevitably seen as loss of strength and the possible psychological reasons behind the symptoms (Gupta, 1994). To exemplify the importance that semen has, there is an Indian belief that weak semen will not produce a male child, which is of great importance in Indian culture. This adds

to the “sense of failure as a man” and the assumption that masturbation results in weak semen and will produce female children (Gupta, 1999).

Jannini, et al. (2006) proposed a new definition of PE, which is a diagnosis based on the pathological IELT, measured by a stopwatch, with a feeling of loss of voluntary control and distress or relational disturbances. From this definition, two different forms of PE arise:

- objective PE, which is defined as severe when ejaculation occurs before penetration or with a IELT of ≤15 s, moderate with a IELT ≤ 1 minute, and mild with a IELT ≤ 2 min), and
- subjective or relational PE, when the loss of voluntary control is experienced with distress by the male or both partners.

There is a growing body of literature supporting the contention of using time to define and stratify the severity of PE, but the limitations of these criteria are, as Sotomayor (2005: 113) indicates “that very few men or their partners know what constitutes normal ejaculatory latency”. Juxtaposed against the use of a stopwatch is the psychological effects; any form of measurement will influence the variable under study (Althof, 2004). Whilst Waldinger (2003; 2004) promotes the use of standardisation in the methodology of clinical trials for PE, it is not known how (if at all) the use of a stopwatch has on the clinical endpoint (Althof, 2004).

Summary of definition

Currently there is no consensus definition of what constitutes PE or what to call it (i.e. early, premature or rapid ejaculation). The two definitions currently used are the DSM-IV and ICD-10, with an additional ejaculatory time measure of less than 1-3 minutes. Both definitions lack clarity over statements such as ‘minimal stimulation’ and ‘shortly after’, as well as difficulties in introducing a ‘scientific’ measure, for example a stopwatch, to time ejaculatory latency, which men find difficult to use, especially if their relationships are already under psychological strain. There is no mention of culture in either definition, and whilst accepting that culture is dynamic and fluid, it would appear that

absence of the cultural context in which sexual activity occurs, negates the meaning of PE for the individual (Steggall and Pryce, 2006; Bonierbale, 2006).

iv) Treatment

Traditional treatment options for PE have focussed on sexual retraining and emotional factors (from Masters and Johnson, 1970) by using stop/start techniques, pause-squeeze, and sensate focus, as well as adoption of a structured behavioural training programme. Although behavioural therapeutic approaches have been suggested as producing success rates ranging between 60 and 90% (Masters and Johnson, 1970; Kaplan, 1974), the results are unsustainable with success rates dwindling to 25% within three years after treatment (Bancroft and Coles, 1976; De Amicus, et al. 1985; Hawton, 1985; Lawrence and Madakasira, 1992; Seftel and Althof, 2000).

Background to behavioural therapy

In 1956, James Semans (an Urologist) described one of the earliest published behavioural interventions for the management of PE – the stop-start technique (Semans, 1956). This approach required the participation of both spouses. After diagnosis of PE, the clinician would meet both spouses to explain the dysfunction and the behavioural programme. The stop-start technique can be used alone, or, as Semans envisaged, the partner would stimulate the penis until the man feels a sensation that is premonitory to ejaculation. At this point, he asks his partner to stop the stimulation until the sensation has diminished. This programme has been adapted for solitary sexual activity, where the man stimulates himself until he feels the sensation premonitory to ejaculation.

Masters and Johnson proposed a similar technique, called the squeeze technique, which also involves the individual and/or couple engaging in masturbation. At the point where the man feels he is going to ejaculate, his partner squeezes the frenulum of the penis for a few seconds (Masters and

Johnson, 1970). This results in a partial loss of erection and loss of desire to ejaculate. After 30 seconds have elapsed, the female partner can resume stimulation. Once the man can delay ejaculation, intercourse can be attempted using the female superior position. During the initial attempts at intercourse, the female is instructed not to move, a technique called the quiet vagina (Althof, 2006).

Both therapies have been adapted in clinical practice (Kaplan, 1974), but the aim of these interventions is to focus the man and his partner on the subjective experience of intercourse (Althof, 2006).

Behavioural approaches to treatment continue to be recommended, but their effectiveness may be dependent on the severity of PE. For some men, behavioural therapy may continue to be a useful intervention in delaying ejaculation. Cooper and Rowland (2005) link the differential features of the diagnosis of PE to Annon's (1976) model for behavioural sex therapy. Annon (1976) describes the PLISSIT model (P = permission, LI= limited information, SS= specific suggestions, and IT= intensive therapy). Cooper and Rowland (2005) go on to suggest their own plan for clinical management of PE (refer to table 2.8).

Table 2.8. An intensity-graded approach to treatment of premature ejaculation that combines cognitive-behavioural and medication interventions (Adapted from Cooper and Rowland, 2005).

Level of disorder	**Suggested cognitive-behavioural interventions**	**Suggested integration of use of medication**
Mild	Education Permission giving	Optional
Moderate	Sensate focus exercises Stop-start or squeeze methods	Suggested
Severe	Intensive training and support Relapse prevention Planned follow-up work	Recommended

Alternative forms of behavioural therapy include training men to learn how to control their arousal without having to interrupt sexual activity (de Carufel and Trudel, 2006). Be this as it may, the effectiveness of behavioural therapies are doubtful, particularly in men with lifelong or primary PE and are premised on the assumption that there are no cultural or religious objections to masturbation, and that partners are willing participants in behavioural therapy (which is not always the case). Since the 1990s, alternative means of treatment have included SSRIs, atypical tricyclic antidepressants and mono-amine oxidase inhibitors (MAOIs), amongst others. Alternative therapies include local anaesthetics and topical creams, for example SS-cream (Berkovitch, et al., 1995; Choi, et al., 1999) aimed at anaesthetising or desensitising the penis and therefore delaying ejaculation. Alternative, non-pharmacological interventions are constriction bands which compress the urethra, and desensitising bands (Jan-Wise and Watson, 2000).

The data from the quantitative studies indicates that paroxetine elicits the longest delay (Waldinger, 2004) and has the least number of side effects. What is apparent from the data is the small sample sizes in the clinical trials (ranging from 3-80 participants) and relatively few drop outs, (between 0 and 15) although anticipated drop outs of 10 and 20% are commonly expected from clinical trials. Varying measures of intravaginal latency have been used, however, there is little or no mention of clinical significance. For example the question can be raised, were the patients (and their partners) satisfied with the delay achieved by using a SSRI?

The drug treatment strategies can be summarised as daily treatment with SSRI/atypical tricyclic antidepressant/MAOI/opiate; ‘as required’ treatment with SSRIs; or topical anaesthetics applied 10 minutes before sexual activity. Dosing regimes for the pharmacological therapies are:

- Paroxetine (20-40mg),
- Clomipramine (10-50mg),
- Sertraline (50-100mg) and
- Fluoxetine (20-40mg)
- Citalopram (20mg)

- Tramadol hydrochloride (25mg) .

Although SSRIs are frequently used these are not without side effects. The most common side effects include fatigue, yawning, mild nausea, loose stools or perspiration. Generally side effects settle within 7-10 days and ejaculatory delay occurs on average within 10-14 days. To limit withdrawal effects of SSRIs, a gradual withdrawal of dosing (every other day dosing) is recommended after 6 weeks of treatment; particularly with paroxetine.
Since 1993 eight studies have been identified (Seagraves, et al. 1993; Haensel, et al. 1996; Strassberg, et al. 1999; Kim and Paick, 1999; McMahon and Touma, 1999; Abdel-Hamid, et al. 2001; Chia 2002; and Salonia et al. 2002) investigating 'as-required' SSRI/MAOI for PE. Results, in terms of ejaculatory delay, are less than in those men who take the medication regularly.

Although SSRIs may provide a statistically (and possibly clinically) significant delay in ejaculation by activation of the 5-HT_{2C} receptor, these only last while the medication is being taken; no long-term benefits have been proven. On cessation of medication, there is a return or a resetting of the normal ejaculatory threshold back to baseline ejaculatory times within 3 to 5 days (Waldinger, 2004; Waldinger, et al. 2004; Mendels, et al. 1995; Kim and Seo, 1998; and McMahon, 1998).

Taking the syndrome of PE as a whole, some men attend clinics seeking pharmacological 'cures'. Many men report high levels of interpersonal distress, which makes engagement with behavioural therapy problematic; their relationships are under considerable strain and their partner is often so frustrated with the poor sexual encounters that they will not engage with any behavioural modification. The demands from this group of patients is for pharmacological (curative) therapy, but SSRIs only provide a temporary masking of symptoms. Their effects only last when taken; after 7-14 days ejaculatory latency time returns to baseline.

The finding that more patients demand pharmacological intervention is reflected in clinical practice and in the literature. The clinical management of PE, particularly for severe PE, is moving from psychological interventions as advocated by the Kinsey Institute and Masters and Johnson, to pharmacological interventions, following the success of studies using SSRIs. This may be in part explained by the apparent failure of behavioural therapies to offer long-term solutions and the difficulty of providing such services. It is certainly attractive to offer a pharmacological therapy. It is easily prescribed, taken, and doesn't need the patient to modify their behaviour; and certainly meets many patients' demands for a tablet to cure them. However, simplifying treatment by using a tablet may lead to an assumption that management of PE is also simple. The drawbacks are that the medication is unlicensed, has no long-term benefits, puts patients at risk of adverse events and does not cure the underlying condition.

Review of treatment options

There are four main treatment options for PE;

- behavioural therapy,
- lidocaine-based creams,
- SSRIs/atypical tricyclic antidepressants/MAOIs and
- constriction bands.

Behavioural therapy is dependent on the motivation of the patient and his partner, which includes whether the treatment stages are culturally acceptable for them. Lidocaine-based creams and sprays anaesthetise or numb the penis, which reduces the enjoyment of sexual activity for some. SSRIs/atypical tricyclic antidepressants/MAOIs, although successful for many men in delaying ejaculation, only do so whilst they are being taken. There are no long-term benefits from using SSRIs and their effects stop within a few days of cessation of treatment. Constriction bands have not proved successful in restoring any form of ejaculatory delay.

Review of the published studies

A summary of the published studies for using paroxetine or other pharmacological interventions indicates the:

- Mean IELT (pre-treatment) is 49 seconds,
- Mean IELT (post-treatment with SSRI) is 288.6 seconds (4 minutes 49 seconds)
- Mean age of men in the clinical trials was 37.3 years, and
- Mean drop-out rate from clinical trials was 10%.

Summary

Clinical management of PE is being polarised between psychological and biomedical approaches (Steggall, et al. 2008) that fail to acknowledge the part knowledge(s) have on understanding sexual activity. In other words, sexual activity is being reduced to a standardised heteronormative construct, which fails to acknowledge the influences of education (or lack of it), cultural mores and experience. The chapter that follows presents the theoretical framework.

Chapter 3

Theoretical Framework (Foucault)

Introduction

Understanding of premature ejaculation, or more specifically the scientific explanations for PE, and has become increasingly medicalised over the last 120 years. Indeed, as Nye (2003) identifies, there is an increasing tendency to portray social and psychological phenomena as medical problems. A psychological discourse was used to explain PE during the first half of the Twentieth Century, but since the mid-1960s, psychological discourses have been largely rejected and replaced by scientific, neurobiological understandings of both the aetiology and clinical management of PE. PE as a discrete entity was first described in the medical literature in 1887, and since then four areas of understanding have evolved based on prevailing psychological and medical theories (Waldinger, 2007). The current theory is that of neurobiology, but this fails to acknowledge any cultural or behavioural descriptors or influences.

This chapter intends to explore the concepts of medicalisation, and to contextualise the subsequent discussion of the philosophy of Foucault and governmentality, which offers a different lens to explore PE and its meanings (refer to Figure 3.1).

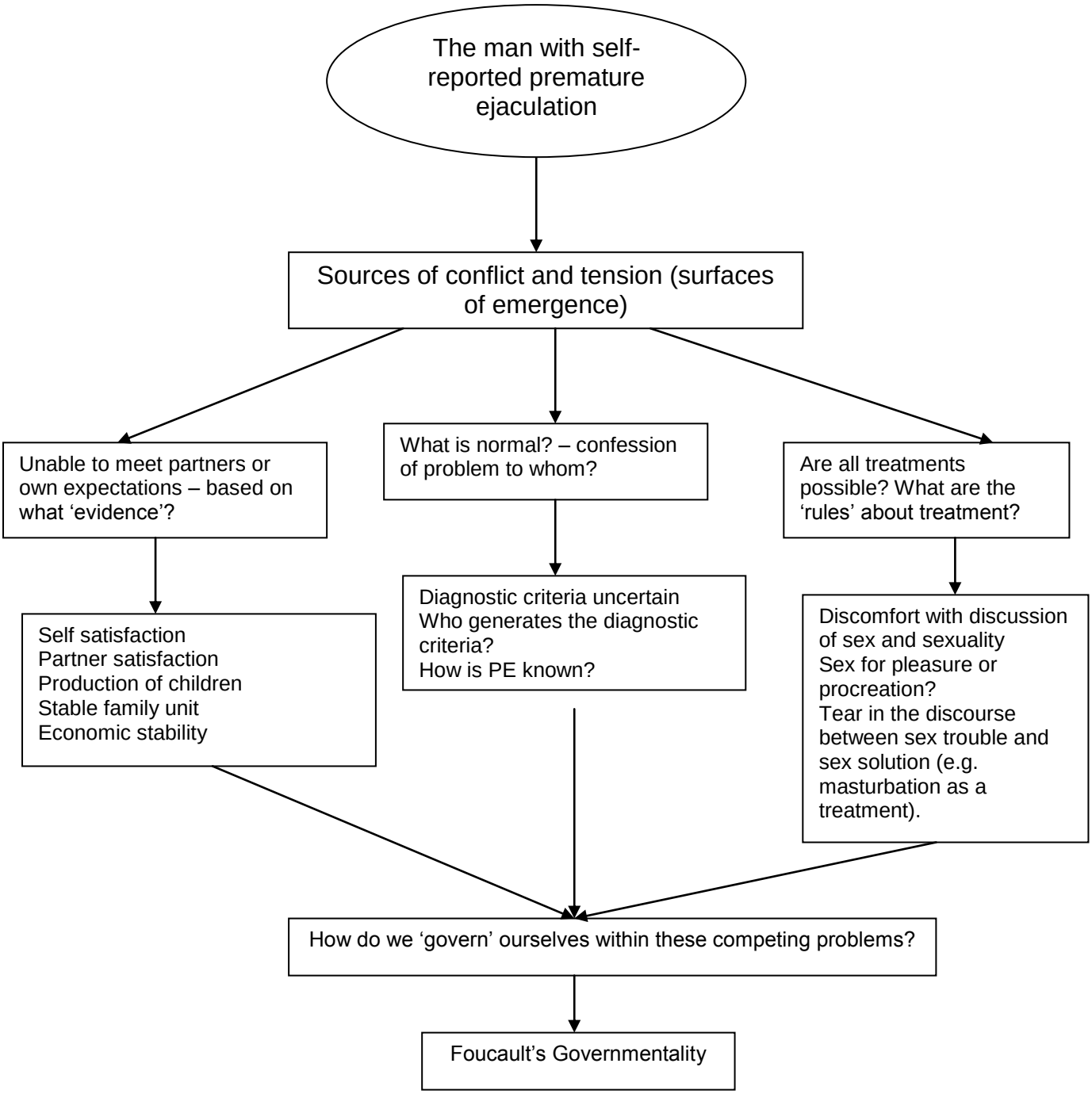


Figure 3.1.Schematic for philosophy or lens through which PE can be viewed

Turner (1995) contends that sexuality is potentiality organised by disciplinary practices, i.e. medicine, psychiatry and religion, and the decision to approach this study from the perspective of these disciplinary practices allows exploration of how different perspectives coalesce to govern men with PE. Furthermore, the decision for adopting this approach was based on clinical experience of treating men with PE. Men, particularly from Muslim

backgrounds, explained the phenomena of PE in terms of distress, inability to meet cultural norms of sexual activity and behaviours, and generally presented a discourse that indicated a separation of body from mind. In essence, Muslim men preferred to medicalise PE themselves, engaging with biomedical discourses but also retaining cultural and psychological caveats in relation to acceptable treatments, and these caveats needed to be explored to offer insights into why particular groups of men seem to be more distressed than others about PE.

The medicalisation of PE by Bangladeshi Muslim men is perhaps not surprising. In Islam, it is the responsibility of the individual to look after his own health; therefore there is a disease (or in this case a syndrome) that is beyond the control of the man. Subsequently the man can shift the locus of ownership from himself to, in this case, the clinician. The cure for PE is accordingly elsewhere, outside the body and his (the patient's) sphere of influence.

The underlying assumption in the design of the research was that psychology and culture *did* play important parts in the milieu of PE, and so rejecting or explaining PE in just neurobiological terms missed the subtle meanings that exist in sexual activity. What appears to have occurred is a move from, as Foucault would say, *Ars Erotica* to *Scientia sexualis*. This chapter presents a review of medicalisation, then introduces the concept of governmentality, which is a means of exploring differing explanations and behaviours that impact men and the decisions that they make.

Medicalisation

Conrad and Schneider (1980: 95) defined medicalisation as a 'major social and intellectual trend whereby medicine, with its distinctive ways of thinking, its models, metaphors, values, agents, and institutions, comes to exercise practical and theoretical authority over particular areas of life'. In essence, activities and experiences are relocated from categories of sexual difference to categories of medical expertise and domination, which is clearly exemplified by the use of a common, generic definition of PE with subsequent

stratification of types of premature ejaculator often based, largely but not exclusively, on time.

There are variations in the definition of medicalisation from Weindling's definition as 'the extension of rational, scientific values in medicine to a wide range of social activities, to Szasz's view of medicalisation as a straightforward conversion of a social and moral problem into a disease' (Lupton, 1997: 25; Wiendling, 1986: 277). As Conrad (1992: 211) suggests, 'medicalisation consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it'.

Medicalisation can consequently influence and construct concepts of sexuality. Conceptual assumptions affect all aspects of 'sexuality theory, research, legislation, education, employment, information, and assistance to people with sexual problems' (Tiefer, 1996: 265), and although medicalisation can be construed as positive (refer to Jannini, 2007), it can also be negative (Tiefer, 1996) by reducing sexual activity into a time-orientated and goal-orientated activity (Steggall and Pryce, 2005).

Foucault wrote about medical intervention into bio-history that first occurred in the 18th century; introducing the term medicalisation and stating that '…human existence, human behaviour, and the human body were brought into an increasingly dense and important network of medicalisation that allowed fewer and fewer things to escape' (Foucault, 2000b: 135). Medicine, or biomedical knowledge, employs a scientific, biological, and naturalised view of the body and of health that emerged during the late 18th Century (Duden, 1991; Gordon, 1988). Some criticise this attempt to identify "core characteristics" of modern medicine as "almost as reductionist as the medical understanding it seeks to interrogate," (Atkinson, 1996: 29).

Foucault rejected the notion that medicalisation proceeded through vertical state initiatives, seeing medical interventions emerging at a 'multitude of sites in the social body of health' (Foucault, 1980: 66). Foucault refers to the state

as a kind of ‘unity’ and attributed to doctors a ‘wilful desire to impose authoritarian medical interventions and controls’ (Foucault, 1980: 81).

Foucault also began to decentre the notion of medical power, locating it in the rules of disciplinary discourses that work on the bodies of individuals, and in particular on children as objects of a kind of reproductive hygiene of families (Foucault, 1980). By the late 1970s Foucault had incorporated the notion of governmentality into his concept of how the modern state ruled the social body (Nye, 2003). In his 1978 lecture on the arts of government, Foucault rejected the notion of an essentialised and wilful state, in favour of a conception of governance that was not based on a juridical notion of sovereignty acting on citizens, but on a set of practices that operated on bodies and on families as reproductive units, while making use of the mechanisms of political economy to motivate and police the population. What this means in terms of relevance to men with PE, is that the condition was not only owned by medicine, it was also owned by multiple structures in society by virtue of the significance of sexual activity, e.g. religion and economics.

Medical practitioners were no longer, in Foucault’s thinking, enforcers or servants of the state but experts in the service of a discourse. The aim of governance was then ‘the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.’ that tacitly reconciles, in the mode of liberal politics, the interests of each with the interest of all (Foucault, 1991: 100).

As Foucault argued in ‘About the Concept of the Dangerous Individual,’ the security of the whole and health of the social body were also advanced by the development in 19th century psychiatry and legal medicine of the concept of the dangerous individual, whose civil rights could be abridged in the name of a higher collective principle and with a medical judgment (Foucault, 2000). This concept can be seen in the discourse from the Imam (refer to table 6.1, page 187) and his observations about the justification for divorce.

Through promotion of the concept of individual responsibility for health, or what Foucault may consider technologies of the self, men with PE must access medicine to become cured and as a result to meet cultural expectations. Medicine as a culture has its own body of knowledge, and a way of knowing that has evolved in conjunction with technology and social values, particularly the social values of the indigenous group (Tiefer, 1996). This is a key point, as members of other social groups can often be seen as exotic others, and their health beliefs or explanations of the normal are overridden or ignored. This process of laying down the boundaries of pathology and norm in bodies and behaviour is a social construction, heavily dependent on medical discourse (Dain, 1989; Herman, 1995; Turner, 1995).

One of the core structures of the medical model is mind-body dualism, where there is a separation of the mind from the body. This is exemplified in the biomedical discourses that seek to identify organic and psychogenic components of PE, amongst other conditions, becoming the modus operandi with sexual complaints. The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) typifies this separation by stating that a physiological cause must first be eliminated, i.e. medical, substance abuse, or medication condition, before assessment of psychological or psychosocial issues are made.

The separation of the biological body from the mind lends itself to the image of “the body as a complex machine, of disease as the consequence of the breakdown of the machine, and of the doctor’s task as repair of the machine” (Engel, 1977: 131), which many patients themselves seem to operationalise. For example, one patient was at pains to say that “I am happy to be in England; in England there is good medicine and good doctors to help fix my problem”. This body-as-mindless-machine metaphor is a central theme in the medicalisation of sexuality, contributing to an emphasis on sexual dysfunction as a disturbance in sexual performance (Tiefer, 1996).

This separation of the mind from body produces a universalised body governed by experimental laws that are independent of the social context or

the culture in which men are embedded (Wright, 1982; 1994) and is apparent in the papers by Waldinger (1998; 2000; 2004). As Tiefer (1996) points out, people have culture; bodies have physiology. The introduction of technology, in this case, the use of a stopwatch to objectively measure ejaculatory time or elucidation of a $5HT_{2C}$ receptor to explain ejaculation, allows a body to be known but without any distortion by the person's health belief, psychology or culture. The measure of time thus becomes a positivistic model of science that allows knowledge of the natural world, ignoring the culture or indeed the history of the person's own sexuality, or the history of sexuality itself.

The deployment of scientific measures is explained by Reiser (1978) as the doctor's doubt about the reliability of patient's descriptions of their bodily experiences, 'suspecting that patients often misrepresented their experiences because of ignorance, miscommunication, or even a deliberate wish to mislead' (Reiser, 1978: 21). This discomfort with self-report data is incontestably identified in the discourses of definition presented in the literature review (chapter two). Only 1 paper has speculated on the acceptability of self-report IELT (refer to Althof, 2004). Although Hirsch, et al. (2004: 88) state that 'clinical trials for treatment of rapid ejaculation should assess efficacy using three basic types of efficacy outcome measures: ejaculatory latency time, ejaculatory control and sexual satisfaction', the strongly held recommendation from Waldinger (2007) is that PE must be defined using an objective and scientific measure. This apparent need to utilise objective measures are based on the premise that 'technology does not lie' (Tiefer and Melman, 1989) but of course the problem with using a stopwatch is that it immediately produces an artificial sexual experience, and as Tiefer (1996) concludes 'interpreting and understanding experiences of the body which do not correspond to our professional, mechanistic, mind-body dualism, takes more than a simple factual correction' (Tiefer, 1996: 260).

Biomedical discourses indicate that illness is something an individual gets; the disease being *in* the body. Although PE has yet to be defined in terms of disease, it has been defined as a syndrome, which for many is synonymous with disease. In DSM-IV, the American Psychiatric Association (APA) states

that “each of the mental disorders is conceptualised as a …..pattern that occurs in an individual” (American Psychiatric Association, 1994: xxvi). Given that the APA definition is so widely used as the diagnostic criteria for PE, it seems incongruous that the *person* has been removed from the syndrome. Nelkin and Tancredi (1987) contend that ‘if biological tests are used to conform people to rigid institutional norms, we risk reducing social tolerance for the variation in social experience. We risk creating a biologic underclass’ (Nelkin and Tancredi, 1987: 176).

A pillar of medicalisation is reductionism, specifically the idea that PE can ultimately, and with greatest precision, be understood via clinical trials and research on their constituent biological elements (e.g. biochemical or neurophysiological processes) (Engel, 1977), although, as Armstrong (1987) points out, ‘this fails to realise that the very concept of disease, in being evaluative, is a reflection not of biological norms but of social ones’ (Armstrong, 1987: 1213). As has been already identified, only those extremely motivated ever seek advice or treatment for PE, and therefore any scientific measurement will be on the most motivated (or most severe) patients and subsequently will not represent those with the condition, leading to the contention that the medical evidence is at best flawed or skewed and should as a result not be taken as fact. Nelkin and Trancredi (1987) suggest that advocates of the biomedical model suggest that scientific research discovers basic physiology that can beneficiently be applied to individuals’ medical problems. Critics of medicalisation claim that scientists aggressively promote basic research for personal ends while using social need as justification (Nelkin and Trancredi, 1987).

When Engel (1979: 260) indicated that “the biomedical model is disease-centred”, the point was made that, in the medical model, diseases, in contrast with people, are the focus of interest (Tiefer, 1996). Cassell (1986: 26) offers an interesting view, ‘Patients have the rather naïve view that when they are sick and go to doctors, the doctors are trying to find out what the matter is. That is not the case. Doctors are trying to find out whether a disease is present’. This depersonalisation results in the attitude, for example, that

because premature ejaculation is a condition which can be described and treated without knowing anything about the culture, health beliefs, or expectations of the man or his partner, they can be ignored. Furthermore, if the patient fails to comply with treatment, the failure is not the fault of incorrect diagnosis or treatment, but rather the failure is due to non-medical psychological, cultural, or relationship factors (Tiefer, 1996).

The alternative to depersonalisation is to view the syndrome as merely labels which arise in culture rather than *in* the body. PE is undeniably influenced by cultural values (relating to gender, pleasure, and sexual scripts), and although medication can be an appropriate element in a treatment plan, a non-medical way to view the complaint is as a discrepancy from the normative sexual scripts which might be appropriately addressed by script changes, attitude changes, psychotherapy and education.

Norms

The central moral component in any biomedical model is the health norm, with diagnostic searches for abnormalities; which in the case of PE is, since the syndrome is so poorly understood, in biological terms. The comparison of any one individual's condition with generalised norms has been gradually replaced by more idiosyncratic conceptions of health and dysfunction (Armstrong, 1983). But are sexual norms the result of scientific laboratory and clinical work, or are they, to repeat Kinsey's ironic language, "scientific classifications…….nearly identical with theologic classifications and with moral pronouncements of the English common law of the 15th Century" (Kinsey, et al., 1948: 202)? As Nye (2003: 120) suggests, 'diagnosis defines the boundary of the normal', but these boundaries are derived from diagnosis and are 'malleable, subject to socially-constructed interpretations…..diagnostic categories may themselves have a social meaning shaped by the needs of social institutions' (Nelkin and Tancredi, 1989: 74). Although few doubt that diagnoses are socially constructed, individuals are still obliged to sort through perceived threats to their own health, whether real or ideological (Nye, 2003).

The moral imperative of health

The final element in medicalisation is that being healthy has become a matter of orthodoxy. As the extract from the field notes (refer to table 6.1, page 191) indicates, there are strong judgements against men who ejaculate too quickly, being labelled as diseased and therefore unfit for marriage. As the imperative of sexual adequacy has grown over the 20th Century, being sexually normal has become regarded as a matter of physical and mental health, and something that individuals will actively regard as being desirable; a concept bound up with Foucault's panopticism.

For many patients, a medical label is actively sought to avoid shame for being a premature ejaculator. This links with Kirmayer's (1988) observation that 'physical examination and medical technology uncover physical abnormalities, a condition is thought 'real' and 'in the body' (i.e. not just reliant on self-report), and thus a patient will more likely be relieved of blame for his condition'.

Medicalisation summary

PE has become increasingly medicalised, where use of ELT has become part of the accepted definition of the syndrome. This presents two problems, the first is the acceptance of a normal ejaculatory time, or indeed a normal location for sexual activities and the second is the de-contextualisation of PE, i.e. the absence of any of the meanings of sexual activity or the culture in which men exist.

Problematisation of the normal

Armstrong (1995) identified that surveillance medicine seeks to assign the individual on a chart, by which his trajectory can be plotted, although this trajectory can only exist in the context of the general population trajectories. By assigning intravaginal ejaculatory latency a time range, and by identifying the 'normal' distribution of ejaculatory latencies (but of only one location of

sexual activity), a trajectory of the premature ejaculator has begun, but this does not account for the experience of ejaculation. It has been suggested by Riley (2007) that normally, sexual activity is mediocre on 6 out of 10 occasions, terrible on 2 out of 10 occasions and excellent on 2 out of 10 occasions, therefore the experience of premature ejaculation, which is different from achieving a particular time, may be different and dependent on the context of the encounter. What this means is that, instead of using ELT as a means of stratifying the premature ejaculator, it locates him on a trajectory where normal becomes the target, but where the enjoyment of the activity is relegated to a peripheral consideration. Furthermore by deploying a stopwatch as a means of identifying this trajectory, there is a reinforcement of time as an index of success.

By comparing the concept of normal ejaculatory times with, as Armstrong (1995) illustrates, growth charts, there can be no delineation by categories of physiology and pathology, but by the characteristics of the normal population. In the case of PE, the normal population is comprised of those willing to confess their ELT and therefore these confessions are of dubious accuracy.

Armstrong (1995: 117) also suggests that ‘concerns with…sex [has] become the vehicle for encouraging the community to survey itself’. Twentieth Century surveillance medicine has focussed more on the interactions between people in the community, needing constant monitoring to guard against transmission of contagious diseases, such as venereal disease. However, the space between bodies is also a psycho-social space which is marked by the shift in the psychiatric/medical gaze from the binary problem of insanity/sanity to the generalised population problems of the neuroses (which affect everyone) (Armstrong, 1979). As Foucault (1973: 88) identified, ‘from the primary spatialisation of illness that linked surface and depth, through the techniques of clinical method that celebrated the volume of that body, to its unencumbered observation in the hospital ward, the medicine of the Clinic defined and redefined a discrete corporal space’. Thus there is knowledge of

what is not normal, but not what is normal coupled with an instruction to “get it sorted out” alone.

Biomedical perspectives assume that normal is used statistically, and refers to the usual or common. Whilst this approach may be useful for some diseases, it fails to explain which biological parameters can be legitimately assessed or how common or rare they are (Armstrong, 1987). Looking at the body as a multiplicity of biological structures and processes, there are hundreds if not thousands of criteria by which any individual is in the abnormal group. But not all these abnormalities represent diseases; only those which are said to interfere with proper functioning, which is subjective.

So how is proper functioning determined? Armstrong (1987) contends that there must be a reliance on *social* assessment of what is expected from individuals, in short, the notion of abnormality embedded in disease is not statistical but the social or ideal. Friedson (1970) observed that disease may or may not have a biological reality, but it *always* has a basis in social reality. In essence all cultures will make (social) evaluations of health/illness processes to identify diseases or their equivalents, which are then explained or contextualised (Young, 1976). What is important to explore is the differences that culture applies to health/illness.

In his account of the emergence of biomedicine at the close of the 18th Century Foucault identified the discovery of what he terms ‘the clinico-pathological correlation’ as the central feature of the ‘new’ medicine (Foucault, 1973). This correlation was based on the supposed link between the biological lesion in the body’s tissues and its manifestation in the clinical realm. Thus inflammation produces pain and tenderness which can be localised outside the body by the patient and the doctors skills at reading signs and symptoms. Towards the end of the 18th century, two core concepts emerged in biomedicine, the symptom/history and the sign/examination. Identification of the symptom (for example, pain) through taking the history,

and by eliciting the sign (for example, tenderness) through the technique of physical examination, the doctor was able to infer the presence of the lesion because of the supposed correlation between inflammation and pain/tenderness (Armstrong, 1987).

There are grounds for arguing that the correlation between the pathological and the clinical is not as clear-cut as medicine might imagine. In part whether there is or is not a relationship between the pathological and the clinical is an empirical issue; but it is also a question about the social practices which govern the production of the correlation.

Summary of the 'normal'

Armstrong (1987) contends that a biopsychosocial approach might be useful in circumstances in which it really is the only way for biomedicine to make sense of a condition, but nothing in it supports its endorsement as the panacea or new model which reconstructs the world of illness. Foucault's notion of surveillance and biopower has been touched upon here and will be explored in the subsequent sections but the discussion offers a point of penetration into the next section of the philosophy underpinning the research, which is that of governmentality.

Governmentality

Governmentality is the relationship between government, where 'government' is defined as 'a form of activity aiming to shape, guide or affect the conduct of some person or persons' and thoughts (Foucault, 1991: 90). It is a calculated and rational activity, undertaken by many authorities, employing a variety of techniques and forms of knowledge. The forms of knowledge identified are medical, psychological and cultural, and in relation to PE, represent forms of knowledge that shape conduct by working through an individuals 'desires, aspirations, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes' (Dean, 1999: 11).

Foucault sees governmentality as a general technical form which encompasses everything from one's self control to the control of populations. Correspondingly, Foucault contends that the important thing in the political arena is to encourage the cultivation of the appropriate governmentality by politicians. For Foucault, this concept replaces his earlier concept of power-knowledge, which has been alluded to in the preceding section.

Governmentality, then, refers to a historically specific economy of power. It refers to societies where power is de-centered and its members play an active role in their own self-governance and because of its active role, individuals need to be regulated from *inside*. Society is based on different institutional domains (family, hospital, school, prison, etc.), and each domain has its own logic. A particular form of governance applies to each domain, and certain knowledge of subjects is produced. The knowledge produced allows the state to govern how individuals will behave in certain contexts from inside the subject, and from the subject itself. What I mean by this is that men with PE need to have their syndrome validated, usually by medicine or psychiatry, and then to conform to acceptable means of treatment, irrespective of whether they clash with cultural understanding or taboos, and there is an entire apparatus by which the premature ejaculator is defined and located.

What has emerged in some of the medical literature is that sexual activity is moving away from *Ars Erotica* where truth was determined from knowledge/pleasure to *Scientia Sexualis* where there is a time-dependent or goal-dependent outcome, particularly where PE is considered with the need to time (with a stopwatch) sexual activity, rather than measure the satisfaction of the couple with each encounter. Although there may be a correlation between time and satisfaction, they are separate entities, defined and described using different scripts and with different meanings.

The knowledge of premature ejaculation is drawn from discourses and measurements, and is further refined through focussed discourse or confession in the clinical environment. A medical/surgical history and a sexual history are taken to explore the nature of premature ejaculation. These are

then linked to the evolving picture of the premature ejaculator, who begins to take on a life and persona of his own. The confessional is akin to the hypomnemata[1] of historical documents and has contributed to the design of this study.

Drawing on governmentality as a theoretical framework enables (and entails) an analysis of 'how we think about governing' (Dean, 1999: 16), in this case an analysis of the ways in which people with PE are regulated, in medical clinics, by psychological discourse and cultural assumptions, as well as their own internal thoughts (which are a product of the society in which they exist).

Governmentality and PE

There are three fundamental types of government, each of which relates to a particular science or discipline: the art of self-government, connected with morality; the art of properly governing a family, which belongs to economy; and finally the science of ruling the state, which concerns politics (Foucault, 1979: 91).

The principle rationale for choosing Foucault was the clinical finding that men presented to the clinic unable to perform certain roles, and hence were outside of a perceived undefined normality. Governmentality seeks to explore the ways in which men are constructed and controlled, not only within a clinical encounter, but in perceived expectations from their own culture. Adoption of governmentality as a concept has been used in various practice arenas, for example, genitourinary medicine clinics (Pryce, 2001) but not in the study of PE. It has been adopted in this research to provide a theoretical framework to explore the relationship between medicine, psychology and culture, as they relate to PE.

Governmentality can be used to explore aspects of the 'regimes of knowledge through which human beings have come to recognise themselves as certain

[1]Hypomnemata is a special type of notebook used in ancient Greek society by variety of people to keep personal records and formulate opinions about the experience of the self.

kinds of creature, the strategies of regulation and tactics of action to which these regimes of knowledge have been connected, and the correlative relations that human beings have established with themselves, in taking themselves as subjects' (Rose, 1998: 11). Popay, et al. (1998) suggested that narrative lay knowledge acts as 'the medium through which people locate themselves within the places they inhabit and determine how to act within and upon them (Popay, et al. 1998: 619).

Governmentality therefore helps to explore 'the games of truth and error through which being is historically constituted as experience; that is as something that can and must be thought' (Foucault, 1985: 6). By experience, Foucault does not refer to something primordial that precedes thought, but to 'the correlation between fields of knowledge, types of normativity, and forms of subjectivity in particular culture' (Foucault, 1985: 3).

An analysis of governmentality therefore 'views practices of government in their complex and variable relations to the different ways in which truth is produced in social, cultural and political practices' (Dean, 1999: 18). In other words, these truths help in governing others and ourselves. 'The ways in which we govern and conduct ourselves give rise to different ways of producing truth' (Dean, 1999: 18). The analytics of government therefore 'starts from the questions we ask concerning our conduct and that of others rather than from a general theory or set of theoretical principles' (Dean, 1999: 27).

There are a number of problematisations, which include what are called acceptable sexual roles and practices, assumed motivations for behaviours, and cultural differences of what constitutes acceptable behaviour. Governmentality seeks to understand how different locales are constituted as authoritative and powerful, how different agents are assembled with specific powers, and how different domains are constituted as governable and administrable. The focus on how questions, then, arises from a rejection of the political *a priori* of the distribution of power and the location of rule. Power, from this point of view, is not a zero-sum game played within an *a priori*

structural distribution. It is rather 'the (mobile and open) resultant of the loose and changing assemblage of governmental techniques, practices and rationalities' (Dean, 1999: 29).

Power, truth and identity mark out three general dimensions of government corresponding to its '*techne*, its *episteme* and its *ethos*' (Dean, 1999: 18). As well as indicating the relation between government and thought, the notion of Governmentality has a second meaning in Foucault's work. Here, governmentality marks the emergence of a distinctly new form of thinking about and exercising of power in certain societies (Foucault, 1991a).

These resultant power relations and situations are among the consequences of how we govern and are governed. To ask how questions of government, then, is also to ask what happens when people govern or are governed. Crucial to the resultant power relations are the capacities and liberties of the various actors and agencies formed in practices of government. To ask how governing works, then, 'is to ask how we are formed as various types of agents with particular capacities and possibilities of action' (Dean, 1999: 29).

The key starting point of an analytics of governmentality is the identification and examination of specific situations in which the activity of governing comes to be called into question, the moments and the situations in which government becomes a problem. This action of calling into question some aspect of the conduct of conduct is generally referred to as 'problematisations' (Dean, 1999: 27). Problematisations are made on the basis of particular regimes of practices of government, with particular techniques, language, grids of analysis and evaluation, forms of knowledge and expertise.

Practices of government as assemblages or regimes

Practices of government cannot be understood as expressions of a particular principle, as reducible to a particular set of relations, or as referring to a single set of problems and functions. They do not form those types of totalities in

which the parts are expressions or instances of the whole. Rather, 'they should be approached as composed of heterogeneous elements having diverse historical trajectories, as polymorphous in their internal and external relations, and as bearing upon a multiple and wide range of problems and issues' (Dean, 1999: 29).

Two aspects of Governmentality will be used to explore the relationship between meanings of PE and institutions of control. Therefore the interconnection between power, knowledge and subjectivity is central to Foucault's theorisation of the relationship between government and thought, and will be explored. Additionally, the role of culture in this interconnection between power, knowledge and subjectivity will be analysed to offer the some insights into to the meanings that men attribute to PE.

Theoretical philosophy and analysis:

Foucault, in The History of Sexuality (1976) examined the power deployed in controlling, labelling, naming and explaining sexuality and normal sexual activity. In The Will to Knowledge (1976) Foucault focussed on the recent history of sexuality, and the functioning of sexuality as a regime of power and related this to the emergence of biopower[2] and biopolitics[3].

Foucault attacked the repressive hypothesis which is the widespread belief that, particularly since the nineteenth century, mankind has repressed their natural sexual drives. A similar assumption can be made in traditional Bangladeshi Muslim culture, where sexual naivety is professed, but women are aware that poor sexual performance is one of the grounds for divorce. Sexuality, contends Foucault, has not been reduced to silence during the Victorian Era, as many contend when suggesting that sexual activity is deeply private and not for discussion. On the contrary, he argued:

[2] Foucault states that it is the practice of modern states to control their subjects by 'an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations' (p.140).

[3] Biopolitics refers to different yet not incompatible concepts. For Foucault, it is the style of government that regulates populations through biopower, for example, how medical discourse creates the premature ejaculator

> '...it put into operation an entire machinery for producing true discourses concerning it. Not only did it speak of sex and compel everyone to do so; it set out to formulate the uniform truth of sex. As if it suspected sex of harbouring a fundamental secret. As if it needed this production of truth. As if it was essential that sex be inscribed not only in an economy of pleasure but in an ordered system of knowledge.' (1978: 69)

The repressive hypothesis can be further refuted by a review of the historical literature of sexual activity. One of the secrets of sex that paradoxically has been endlessly revisited is masturbation, which is implicated as both a cause and 'cure' of PE.

The fundamental point is evidently that sexual drives were not repressed but rather controlled, a term that Foucault refers to as biopower.

Biopower

Foucault defines biopower as the technology of power, or a way of exercising power which encompasses various techniques into a single technology of power. For example, in premature ejaculation, the criterion for diagnosis is evolving to include a measure of time (i.e. ELT) to further stratify ejaculatory dysfunction (Lue, et al. 2004; Waldinger, 2005). Pharmacological treatment is recommended for severe premature ejaculators with an ELT of less than 2 minutes. Waldinger (2006) goes on to suggest that for men with an ELT over more than 3 minutes, psychotherapy should be offered. These time distinctions reduce sexual activity into a time-orientated experience rather than a mutually affirming one (Steggall and Pryce, 2006). Furthermore, this makes the management of the condition the preserve of prescriber's, i.e. medical practitioners, if a timeframe criterion is used.

Foucault categorises biopower into two basic forms: *"Anatamo-politics of the body"*, the integration of the human body into systems of economic controls

and *"biopolitics of the population"* the supervision of the "species body"; its births, deaths, life expectancy, etc. (Foucault, 1998: 100).

In describing how biopower is exercised, Foucault looked to the medicalisation of the family unit, whereby the family is assigned a linking role between general objectives regarding the good health of the social body and individuals' desire or need for care. This enables a private ethic of good health as the reciprocal duty of people to be absorbed into a collective system of hygiene, i.e. to not engage in masturbation and inappropriate sexual activity (however defined by the predominant power), which is akin to the principles of Islam. Scientific techniques of cure are made available to individuals and demanded by a professional corps of doctors qualified and, as it were, recommended by the state (Foucault, 2000).

PE is the point of articulation between normal function and dysfunction, i.e. there is a normal sexual function and an abnormal one, and the definition of abnormal lies in confession to the medical profession; even though the individual articulates it, the State confirms it for without a clinical diagnosis the condition only exists at a point beyond the regulation of medicine.

Foucault was also concerned with the archaeology and genealogy of knowledge (Danaher, et al. 2000). In describing archaeology of knowledge, Foucault writes "one is trying to uncover…discursive practises in so far as they give rise to a corpus of knowledge, in so far as they assume the status and role of a science" (Foucault, 2002: 210). This links with cultural discourses that have shaped understanding of the aetiology of PE, and Foucault urges us to examine knowledge through the development of discourse, which he defines as "a group of statements in so far as they belong to the same discursive formation" (Foucault, 2002: 131).

Foucault defines discursive formations, being made up of the elementary units of statements, as "groups of verbal performances that are not linked to one another at the *sentence* level by grammatical…links; which are not linked either at the *formulation* level by psychological links…but which are linked at

the *statement* level" (Foucault, 2002: 129). He goes on to say that "they are institutionalized, received, used, re-used, combined together…they become objects of appropriation, instruments for desire or interest, elements for strategy" (Foucault, 2002: 129). Therefore, Foucault attributes the formation of knowledge to the development of discursive formations. This development does not follow a process of evolution throughout history, instead being subjected to "ruptures" and "realignments" but does maintain an essence of itself, a way of speaking particularly to its speciality e.g. "medical jargon".

Ruptures occur in the discourse, due for example in medical discourse to scientific advances, i.e. the finding that SSRIs can delay ejaculation, challenges the behavioural perspectives discussed by Master's and Johnson (1970). By making discourse through an institutional site, for example in a clinical environment, the discourse derives a "legitimate source and point of application" (Foucault, 2002: 56). Thus a clinician, making discourse within the institution of the clinic about premature ejaculation, both uses and creates knowledge (medical discourse) and is able, by virtue of medicine's status in society, to exercise biopower.

Biopower has been justified rationally and the use of biopower is firmly embedded within the concept of evidence-based medicine and healthcare, with emphasis on the protection of life rather than the threat of death, the regulation of the body, and the production of other technologies of power, such as the notion of sexuality. Although Foucault defines power as positive, in opposition to the classic understanding of power as basically negative, limitative and akin to censorship, Foucault (1980: 89) has suggested that sexuality has been subjected to a "sexuality dispositif" (or "mechanism"), which incites and even forced the subject to speak about his sex. Thus, "sexuality does not exist", it is a discursive creation, which makes people believe that sexuality contains their personal truth. The significance of this insight illuminates some of the narratives and health beliefs of men presenting with premature ejaculation. Although apparently embarrassed by the condition and confess to be sexually naïve prior to marriage, men (and their partners)

are clear about what is required in terms of ejaculatory delay, which indicates that sex is a subject of intense discussion.

This concept of regulation is one that shines clearly through the narratives of men attending for advice. For example, participant Z reported “men who have PE are not men – they are considered not a proper man by their women, and so he is ignored and laughed at….this is very shameful. What is the point (of existing)?” Governmentality, or an exploration of this concept, therefore allows analysis of three key questions:

1. How are men with PE governed within the discursive field of the ED clinic?
2. How do men with PE govern themselves within this discursive field?; and
3. What are some of the consequences and implications of the ways in which men with PE are governed and govern themselves within the discursive field of the ED clinic?

A core concept in an analysis of governmentality and the basis of these key questions is panopticism.

Panopticism

Panopticism defined by Foucault (1984) is an anatomy of power, which can be based within an institution or used by an institution as a means of reinforcing internal mechanisms of power. An illustration of this concept can be drawn from clinical practice. Men with PE are expected to confess their condition to a medical practitioner, who, in some cases, deploys diagnostic criteria and tests to objectively or scientifically confirm the diagnosis. Thus, there is a disciplinary power (medical/psychiatry/nursing) that positions the patient into an apparatus of diagnosis. Although the patient’s history is undoubtedly taken into account, there is evident tension (particularly apparent in the literature), if his definition and personal knowledge of PE differs from that of the clinician.

Components of the panoptic, or the elements by which power is deployed, include economic and legal (juridico-political) concepts (Rabinow, 1984), as well as scientific rationality.

The first criteria in the exercise of power is to operate at the lowest cost; the second is to bring the effect of social power to its maximum intensity; and finally to link economic growth with technologies of power. By this is meant PE is controlled within clinical medicine or psychiatry, is defined within a time criterion, and successful cure allows reproduction, or at least, the maintenance of a stable relationship within which children can be raised. This is further illustrated by a text drawn from an Islamic advice web site (www.Islamicity.co.uk):

> 'Is premature ejaculation a reason for a wife to divorce; I know that impotence is a reason, but if someone comes after 10 or 20 seconds, how is it in this case?'
>
> **Answer**
>
> 'We put this question to Shaykh Muhammad ibn Saalih al-'Uthaymeen, who replied that if this is upsetting the wife and causing her to miss out on her own pleasure, then there is nothing wrong with her asking for a divorce, but if she has children she should not be too hasty. And Allaah knows best.'

Beliefs about the power and strength of semen are common in the discourses of men attending the ED clinic, thus economics and PE are inextricably linked for some patients. Economic disciplines also fix or regulate movements, clearing up confusion and neutralising counter-power, which is clear in the differing opinions of causation and treatment of PE (refer to Waldinger (2005) and Steggall and Pryce (2005).

Summary

Premature ejaculation is, in some respects, a simple clinical problem: how is ejaculation delayed so that the man (and his partner) are satisfied with their sexual encounters? However, sexual activity is in itself a multifaceted event, with different meanings, consequences and interpretations for each individual engaged in it. The investigation into clinical management involves examining the phenomena from several differing but in some respects, complementary perspectives. Governmentality is not about representations of individual mind or consciousness, but of 'the bodies of knowledge, belief and opinion in which we are immersed' (Dean, 1999: 16)

The use of Foucault's philosophical paradigm has been selected to serve as the theoretical foundation of the research. The advantages of using Foucault's theory as a foundation is that it is essential to explore the construct of premature ejaculation from diverse perspectives, i.e. medicine, society, the person and his partner, societal and religious expectations of normality, because the premature ejaculator is a product and participant in all, or many, of these spheres. Foucault's theories, particularly in relation to power, can be clearly applied to the clinical management of premature ejaculation.

Chapter 4

Methods

Introduction

The preceding chapter described the philosophical perspective that informs the research. This chapter presents the rationale for the method chosen to conduct the research, as well as how the data were gathered and produced. A thematic approach was taken to explore the discourses and position of men with PE. In order to conduct such analysis, it was necessary to generate textual forms of data that 'constitute mentalities of governmental reasoning' (Osborne, 1997: 176) and provide an array of discourses through which men with PE are formed and regulated within the discursive field of the urology/erectile dysfunction clinic.

The research question

What are the factors that form Bangladeshi Muslim men's knowledge(s) of premature ejaculation?

Design and Method

Miller and Crabtree (2000) suggest that some available research styles for clinically focussed research include:

- Experimental
- Survey
- Documentary-historical
- Field (qualitative)
- Philosophical
- Action/participatory

The style adopted for this research combined experimental, field, documentary and philosophical, to allow use of multiple sources and types of knowledge, which will allow interpretation of the context and meanings of PE. Much of the published clinical literature does not contextualise or texture the subject of PE, and therefore an approach aimed at redressing this balance was adopted; gathering insights into the subjective experience of PE. Measurement of ejaculatory latency and semi-structured interviews allowed this gap in the knowledge to be explored.

Sampling techniques

The data for the qualitative analysis was drawn from a randomised trial comparing treatment interventions. 144 men were required for completion of the RCT, but for the qualitative research, data collection ceased once saturation in responses was reached. The inclusion and exclusion criteria are reproduced in table 4.1.

Table 4.1 Inclusion/exclusion criteria

Inclusion	*Exclusion*
Male over 18-years of age Symptoms of rapid ejaculation for > 6-months Capable of independently completing the questionnaire The subject has given informed consent, for which he has signed and dated the informed consent form The subject must be in a stable relationship for more than 6 months The subject must have only one sexual partner Must attempt sexual intercourse once per week (minimum 4 times per month)	Individuals currently undergoing psychiatric treatment New casual relationships Contra-indications for SSRIs MAOI use Poorly controlled epilepsy Concurrent electro-convulsive therapy History of mania Hepatic or renal impairment Retroviral Medication Treatment for rapid ejaculation within the last 3 months IELT > 4 minutes

The inclusion/exclusion criteria were devised for participation in the RCT rather than solely for the qualitative arm of the research. The exclusion criteria were influenced by the randomisation to receive pharmacological intervention, and therefore the contra-indications to SSRIs, e.g. mania, retroviral medication, etc. formed part of the exclusion criteria. No patient had a history of depression and as far as could be ascertained, and did not have any medication prescribed that would indicate a diagnosis of depression. Participants were able to understand English even though English was not their first language. Data gained is only from men meeting the criteria; single men, or men with multiple sexual partners were excluded from the trial, although during the period of data collection, only 4 men were excluded from the trial because they did not meet the eligibility criteria.

Method

Men with PE referred to the ED clinic were invited to participate in the research. If they agreed to participate, a patient information sheet was provided and a follow-up (consent) appointment arranged for two weeks' later. At the second visit, participants were consented, interviewed and randomised to receive either paroxetine 20mg daily or Premjact spray 3-8 sprays (lidocaine-based spray) applied to the frenulum and glans penis 10 minutes before sexual activity. Premjact spray was selected because it was easier to use and quicker acting than, for example, EMLA cream (which takes 60 minutes to work). Patients were instructed to begin with 3 sprays 8-10 cm away from the penis. They could increase the number of sprays according to effects. There were no reports of erectile dysfunction with either paroxetine or Premjact spray. Each pharmacological intervention was for a 2 month period. After 2 months, the participants were given a behavioural therapy programme designed by a sex therapist and comprised: sensate focus for one week; man-on-top position (penile insertion into vagina but no movement) for two weeks; man-on-top position (with thrusting – stop/start) for two weeks; the final phase of the programme was any position with stop/start technique as needed. Participants were asked to record ELT with a stopwatch at each attempt.

The qualitative data utilised a semi-structured data collection sheet to help identify particular themes and health beliefs once consent to participate had been obtained. Interviewing is a common practice for generating texts for analysis in qualitative research (Wolcott, 2001). The semi-structured interviews helped to produce a complementary account of what it is like to be diagnosed, and to live with, PE; what the main motivators for seeking treatment are; and to gain insights into the expectations of particular groups (or cultures) in terms of normal sexual activity. These texts generated a multiplicity of (contradictory) discourses through which men with PE are constituted, and through which they constitute themselves as subjects and objects of regulation, within the discursive field of the ED/Urology clinic.

Interviewing men with PE allowed generation of discursively rich texts incorporating a variety of discourses that have been influenced from sources such as the Internet, GPs, Imams and peers. Most men had sought advice from a healthcare profession, either in the UK or in their home county, and these discourses were explored in the interviews, which provided insights into the meaning of PE.

Context of the research

All patients were seen in a new PE clinic (opened for the purpose of the research). The PE clinic was held every Wednesday, had timed appointments (usually 30 minutes) and only saw men (and their partners if possible) with a provisional diagnosis of PE. The clinician and researcher was the same individual. The reason for this was two-fold, firstly the clinician needed to answer a clinical problem and secondly the absence of suitably qualified individuals to assess and manage men with PE. Health advocates (and interpreters) were offered to men who requested this service. However, men with PE, particularly Bangladeshi men, did not want anyone else with them during the consultation; indeed consultations were often completed in a mixture of Sylheti and English because these men refused to have an advocate/interpreter present for fear that their community would get to know that they had a sexual problem. On one occasion, an entire history was

invalidated because the patient confessed that the history he provided whilst the advocate was present was completely fabricated because he was so embarrassed.

The clinic was situated in a clinical treatment room that shares space with Day Surgery. The room is normally set out for urethral catheterisation/instillation of intravesical chemotherapy, and has several cage racks containing clinical equipment. A desk with a computer screen allows the clinician a small space to write clinical notes while the patient, sitting to the right and slightly behind the clinician, discusses their condition. The décor of the room quite clearly suggests clinical intervention, but not for PE, thus giving the clinical space a feel of fitting the patient into a busy clinical space. There is a waiting area for patients shared by the relatives of patients undergoing day surgery. There is a television attached to the wall, some reading material and various posters advertising urological problems, complaints procedures, and leaflets about how to obtain patient transport. The decoration of the clinical room is an unintended off-white colour. There are two old chairs available for patients, and the corridor is full of equipment to be stored, as well as being the location for the Crash trolley. Opposite the clinic room are the Gentleman's and Ladies' toilets. The gentleman's toilet does not have a door; urine is left in this space for testing. In essence, the clinic setting is unsuitable for discussing sexual problems, and is not a comfortable space in which to conduct consultations.

Recruitment of participants

All men seen in the PE clinic were offered the same treatment choices, i.e. various forms of behavioural therapy (pause-squeeze, stop-start and sensate focus techniques); selective serotonin reuptake inhibitors (SSRIs) – usually paroxetine 20mg daily; Premjact spray (9.6% lidocaine-based spray); a constriction band; or participation in the research trial. All men attending the clinic were given a patient information sheet (refer to appendix two); if they agreed to participate an appointment made for review in 2 weeks to enable stopwatch ELT recording and time to discuss participation in the trial with their

partner. At the second visit men were asked whether they confirmed that they wished to participate; those who did signed a consent form and were interviewed and given active treatment. Men who did not wish to participate were offered one of the treatment options and followed up in the PE clinic 10-12 weeks later. Their demographic details/clinical histories were not transcribed for analysis.

Description of the participants

Participants were drawn from referrals to the clinic. The local catchment area included Tower Hamlets, City and Hackney, and Newham, which are in the London Boroughs of Tower Hamlets, Hackney, and Newham. The participants were interviewed individually (their partners usually failed to attend with them although they were not excluded) and the semi-structured interview questions were used to guide the discussions.

Saturation levels for the qualitative phase of the research was reached after 15 patients, but continued until 36 men had been recruited to the research. For the purposes of analysis, 23 Bangladeshi men were included. Details of recruitment are in table 4.2.

Table 4.2 Recruitment log

Recruitment log	
Invited	111
Attended	58
Did not attend appointment(s)	53
Consented	43

The mean age of the research participants at presentation was 40.8 years (range 23-69 years). Demographic data is recorded in Figures 4.1 and 4.2.

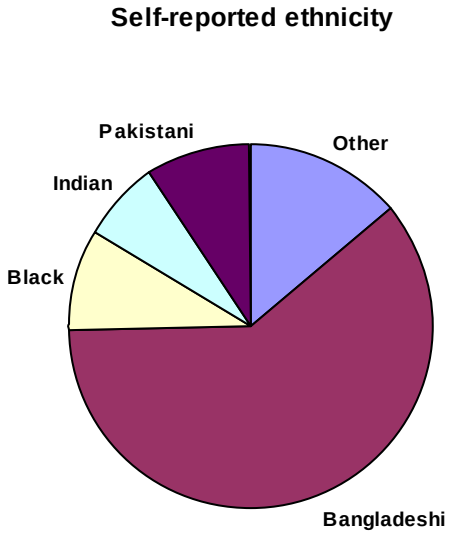


Figure 4.1 Self-reported ethnicity

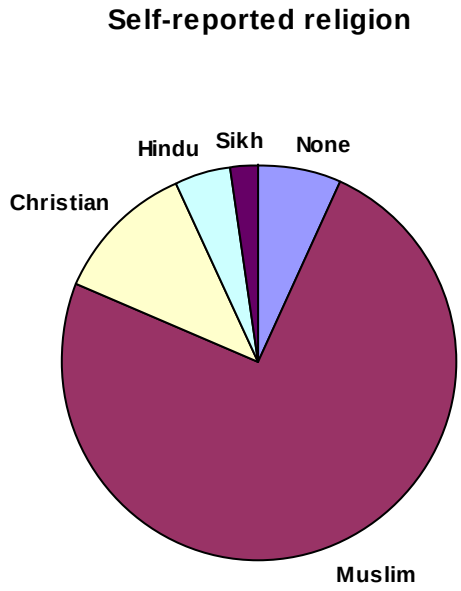


Figure 4.2 Self-reported religion

The Interviewing process

All participants were asked the same set questions. The participants were interviewed individually (their partners usually failed to attend with them

although they were not excluded) and the clinical history sheet was used to guide the discussions.

The semi-structured interview approach allowed both form (in the form of an interview theme list of topics of interest to the interviewer) and flexibility (by allowing interviews to flow in a conversational manner). The interviews were transcribed during the consultation, with particular attention made to ensuring that exactly what was said was transcribed. The semi-structured interviews were focussed round a 'theme list' or inventory of important topics. The theme list took the form of a 4-page question sheet that asked direct questions about various issues related to the meanings of PE within solitary or joint sexual activity. These themes sought to uncover some of the problems that men with PE have. In addition, ethnographic observations were made immediately after the consultation and appended to the history sheet.

Ethical considerations (and informed consent)

COREC, MHRA and local ethical committees were approached to approve the research and all aspects of the trial were granted approval (refer to appendix three and four). In addition, funding for the research was secured from the Barts and the London NHS Trust Charitable Foundation - Research Advisory Board (RAB), who further assessed the validity of the research using peer review before awarding the grant. Given the sensitive nature of the topic under discussion in the interviews, it was important to give time and attention to the ethical issues that arose from this research. The ethics application clearly stated that the research was both qualitative and quantitative in design, and that discussions of sexual activity would be explicitly included. In addition to these statutory regulatory authorities the research protocol was given to the local Imam and to the President of the Shari' a council of Great Britain, who also gave approval for the research (refer to appendix five).

One of the ethical concerns included potentially disadvantaged or marginalised groups. As predicted from clinical practice, most participants were Bangladeshi Muslim men and therefore for the purposes of analysis,

these men alone formed the basis of the analysis. These men can be considered as disadvantaged from a number of perspectives – poor education, English spoken as a second language, reluctance to travel outside of the Bangladeshi area of East London; all of which made attendance at the clinic more problematic for these men. Recruitment levels may well have been higher had the research been conducted at a different site, but due to constraints in clinical space, the research was conducted in the same venue as the existing ED clinic.

Patients were advised that their participation was voluntary and they could withdraw consent to participate at any time without their future care being affected.

Generation of texts

The generated texts were taken from the clinical trial schedule of questions and therefore only concern itself with one particular axis of tension, meaning that the subject of PE is much more than that elicited within clinical discourse, but that discourse about PE is readily available within this clinical setting. Thus the clinic provides a space or location whereby a problem is encountered, which is referred to as a problem-space. The problem spaces were identified through the review of the literature and the clinical trial, and participants' responses to the semi-structured questions which were designed to add participants' meanings to the identified problem spaces. To illustrate, medical literature positions the premature ejaculator in particular space, for example, the clinic, and the literature is based on the knowledge generated from this space. For the man with PE, the experience of the condition is outside of this space and it is therefore intriguing to see how clinical medicine can filter the experiences of the clinical space into a discourse about PE. What exist are the discourses of one particular axis of knowledge and not the meanings of PE that individuals have.

The medical literature does not concern itself with the contextual discourse of the individual and therefore does not capture the meanings of PE between

culture nor the individual's partner; both of which can influence the condition. Although partners were not excluded from the clinical encounters, few attended the clinic, and those who did rarely offered an opinion, however, any narratives that aided further explanation of the cultural or partner perspectives were included as 'obiter dicta' statements, and were included in the analysis.
From the literature and respondent's replies, a thematic approach was used to analyse the data, but in addition to this, a lens was used to position or focus the subsequent analysis. Foucault's concept of governmentality forms the theoretical framework that underpins the analysis of how men with PE govern themselves, are governed by their partners, and exposes how the apparatus of the clinic validates and legitimises this condition.

Research using governmentality requires analysis of a range of forms of data, and the data forms generated for the present analysis reflect the multiple discursive practices through which PE and men with PE are problematised within the discursive field of the ED/PE clinic. Dean suggested:

> 'Studies of governmentality are not concerned with a general figure of the self bound by a necessary social determination but with the more less explicit attempts to problematise our lives…' (Dean, 1999: 217)

Men with PE are enmeshed in matrices of power/knowledge that are an outcome of them entering the clinical setting. These power matrices are within themselves and how they meet cultural expectations, from their wives/partners who have (perhaps uninformed or different) agendas and expectations about normal sexual activity (however defined), and from medicine/psychology where competing discourses seek to explain, control and almost own clinical management of PE.

The ED/Urology clinic forms the structure through which individuals are diagnosed, and therefore diagnosed or named as men with PE. It is through this discursive field, and the associated relations of power and knowledge, that PE and men with PE are constituted as objects and subjects of discourse, exemplified by the biomedical discourse and reductive approaches to sexual activity by focussing on a time-focussed experience (i.e. using stopwatches)

instead of mutual satisfaction as an outcome measure. This is not to reject the importance of time but to rather re-position its significance to the equally important subjective experience of PE.

The approach to the analysis used in this thesis, which requires the analysis of both the published and transcribed data, will be discussed, but will first focus on the processes through which the data were generated.

Creating the space

Creating the space refers to inclusion of all stakeholders in the design of the trial. Miller and Crabtree (2000) refer to voices that are outside the walls of traditionally designed trials, i.e. the absence of patient and partners concerns, or the hidden influences of religious leaders/cultures. The advantage of including these absent voices is that the clinical question(s) can be driven by both the clinician and patient (and their partner), which results in a project that is focussed on common ground (Taylor, 1993). The common ground in the case of clinical management of premature ejaculation is rather difficult to define, since no common ground exists in terms of clinical management or meanings of PE, but for the purposes of the research the common ground includes exploring the cultural meanings of premature ejaculation, as well as normal expectations of sexual activity from diverse perspectives (culture, medicine and psychology), or as Parker (1992) suggests:

> 'The analysis of texts has to be placed in cultural context, and an understanding of discourse dynamics developed in an account of tensions and transformations in culture' (Parker, 1992: 21)

To achieve this cultural context the entire project was examined by a focus group of patients, clinicians and community leaders, and was supported by the President of the Shari'a Council of Great Britain (refer to appendix five). Ethical and MHRA approval was granted for both the randomised trial, where the data was gathered in the form of a semi-structured interview schedule.

The semi-structured questions aimed to discover the missing evidence, experiences, and contexts, the richness and depth of what effectiveness means; to explore the human implications of treatments, and to enter the conflicting landscape of alternative and conventional medicine (or rather to explore the meanings and rationalities of illness and normality for each man with PE).

Prior clinical and research experience indicated that Bangladeshi Muslim men did not readily participate in research trials and were anxious about revealing personal information in the belief that members of their local community would in someway hear about personal information. Use of recording devices, health inventories and even health advocates was difficult or impossible to use for fear (in the patient's mind) that confidentiality would be breached. Even during face to face interviews, inaccuracies existed, for example, one participant being interviewed by a female colleague later told me that what he said was a complete fabrication because he was so embarrassed. The draw-back of noting being able to record the interviews contemporaneously was that subtleties were lost, although this had to be balanced against the participants' wishes.

Although the dominant biomedical paradigm of evidence based medicine used in the randomised trial is rooted in patriarchal positivism, control through rationality and separation is the over-riding theme. It creates a space by which tensions can be explored by identification of common themes, which justifies the use of this methodology:

- Scientific rationality (e.g. does deployment of a stopwatch 'objectively' measure IELT?)
- Emphasis of *individual autonomy*, rather than on family or community (e.g. does this provide useful meanings into the clinical problem of PE?)
- The body as machine, with emphasis on physiochemical data and objective, numerical measurement (e.g. does this separation of mind and body mirror patient narratives, and if so, what reasons are there for such separation?).

The critique of the biomedical model suggests a number of disadvantages in this methodology that include the assumption that it represents a paradigm and practice that is:

1. Male-dominated (and heteronormative)
2. Physician-dominated
3. Specialist orientation
4. A process of orientation accentuating ritual, with supervaluation on 'science' and technology
5. Therapeutic activism with emphasis on short-term results
6. Division of clinical space
7. The definition, importance, and sanctity of 'medical time'
8. Emphasis on patient satisfaction
9. Reverence for the privacy of the doctor-patient relationship
10. Intolerance of other modalities (Helman, 1994).

Miller and Crabtree (2000) contend that these positivistic assumptions, values, and beliefs characterise the dominant voice of the medical clinic and define the boundaries of clinical research. This is clearly articulated in the papers from Waldinger, and his insistence on objective measures time to qualify and stratify PE based on time and use of a stopwatch. Furthermore, both definitions (discussed later) used to diagnose PE make assumptions based on the notion of time.

Biomedical culture is reinforced and sustained by its fit within the prevailing clinical culture of evidence-based medicine and erosion of the individual voice in healthcare. The normalising ideologies are again reinforced by the clinical space in which patients are seen and observed. The medical literature is characterised as being atheoretical, hospital based and disease focussed.

Biomedical or clinical research does however allow a qualitative approach to be used. A qualitative model of biomedical research has been proposed by Miller and Crabtree (2000) by adopting a many-eyed model of mediation. They suggest that this model is based on:

1. Being centred *in* the clinical world

2. Focus on questions drawn there
3. Assume both/and acknowledge what is of value in biomedicine *and* highlight what is missing, what is silent, invisible, ignored; expand on the already existing tensions
4. Follow a *natural history* path that characterises indigenous medical traditions and the early history of Western medicine
5. Be participatory; include patients in the inquiry work
6. Preserve and celebrate anomalies, the discoveries and data that do not fit; anomalies are the levers for transformation
7. Allow truth to be *emergent* and not pre-conceived, defensive or forceful

This model has been adopted and used throughout the research and used to form the problem spaces by which premature ejaculation is examined. The definition, importance, and sanctity of medical time is a point for further analysis since there is a high non-compliance rate with PE management, which may represent a collision not only between clinician and patient, but between the patient's desire for cure and the reluctance to reduce sexual activity to a scientific ritual.

Reviewing the critique of biomedical treatment, I turn now to an exploration of some areas of tension when using this method.

The reverence for the privacy of the doctor-patient relationship (certainly true for some patients who are terrified that confidentiality will be breached and that others will know that he is a premature ejaculator) and Intolerance for other modalities are evident in the discourses and publications offering an alternative perspective to clinical management of PE (refer to Steggall and Pryce, 2006a; 2006b).

Although the positivistic assumptions, values, and beliefs characterise the dominant voice of the medical clinic and currently define the preferred boundaries of clinical research, these need not be considered negative, for as Foucault suggests, power is positive and in opposition to the classic understanding of power as basically negative, limitative and akin to

censorship. These fit within the prevailing cultural norms of the UK; the normalising ideologies include control over the environment; rational determinism; future orientation; life as an ordered and continuous whole; and individualism with emphasis on productivity, perseverance, self-determination, and self-reliance (Miller and Crabtree, 2000).

Whilst these discourses are manifested in discussions of the family, self, gender identity, and ageing, there are differences between these discourses that are shaped by culture, religious and health belief. For example, the discourses that are used to explain the phenomena of premature ejaculation are different depending on the cultural background of the patient. For some, discourses centre on physiology/psychology, whilst for others' it is the mystical power of semen and the health-beliefs that weak semen is a cause for PE (as well as production of female off-spring). Both patients and physicians refer to these ideologies and their discourses to help them restore order and normalcy to the disruption of sickness (Becker, 1997), and to rationalise their PE.

These discourses, coupled with the positivistic prevailing culture of the UK may account for the demand for biomedical intervention for treatment. There is value accorded pharmacological and scientific interventions, rather than behavioural intervention. Additionally, the discourses are male, in that only men can engage with the discourses (particularly Muslim men) because their female partners refuse collaboration in attending the clinical space and will not discuss with clinicians any sexual dysfunction.

The clinically grounded research questions for exploring the phenomenon of premature ejaculation include:

1. Why has an IELT measure been treated as the acceptable end-point for clinical trials?

2. What are the predominant themes in the literature and how do these conflict with patient expectations?

3. How do men govern themselves or make sense of their clinical world? and

4. How are men governed within the discursive field of a sexual dysfunction clinic?

Each of these questions has emotional, physical/behavioural, conceptual/attributional, cultural/social/historical, and spiritual/energetic ramifications, for example:

- How does past experience connect to the immediate experience of PE?
- There are questions of power about how people are supported, i.e. who has the power? The patient, their partner or the clinician (or how is this power deployed?)
- How is emotional distress surfaced or suppressed?
- Who influences whom?
- What are the local politics (i.e. referral pathways) and does local politics influence referral routes?

The existing evidence-based medical approach to the clinical management of premature ejaculation lacks the context and meaning of inappropriately early semen loss and therefore analysing the literature and narratives from participants allows the clinician to explore tensions in clinical practice that are specific and real to his patient group.

Participatory and Advocacy Strategies

Miller and Crabtree (2000) propose that research emerges from clinical experience with the clinical participants, with focus on underlying values and assumptions. This refocuses the gaze of clinical research onto the clinical experience and redefines its boundaries. This approach is termed as the relationship-centred clinical method (RCCM), which has four separate processes – exploring, understanding, finding common ground and self-

reflection. These four processes flow sequentially, but all iterate with each other during any particular encounter, and the whole process cycles multiple times for any given illness episode.

These four processes of the RCCM correspond directly to the four processes of qualitative research, i.e. gathering, analysis, interpretation, and reflexivity:

- Clinicians gather data
- Focus the interviews – touch on possible explanations
- Exploration seeks disease information in a biomedical and an anthropological way
- Analysis occurs immediately; an attempt is made to understand the condition from the patient's perspective
- The clinician shares information about the condition
- Outcomes are dictated and reported.

What is being examined?

The research examines the phenomena of PE for each individual who experiences it. The truth of PE is made by confession and the medical discourse over the construction of normality/abnormality. Exploration of truth however, is problematic, as Parker (1992) comments:

> 'We should abandon the fetish for truth and recognise the essentially fictional nature of human existence' (Parker, 1992: 85)

The truth of PE does however require exploration, not in a reductive sense, i.e. by measuring IELT with a stopwatch, but in the sense that there are varying and contradictory narratives that compete to offer truth and some of these truths come into conflict. A collision between various individual's perspectives on truth that come together in a particularly dysfunctional way occurs when one considers premature ejaculation. The 'truth' for the man is often different from the truth of his partner, but because his partner does not (or cannot) engage in the discussion of their collective 'truths' clinicians are unable to make sense of their discourse, so have to filter their discourse

through the clinical encounter, or employ a clinical gaze that may not be in tune with the reality of the man or his partner. There is then a collision in terms of clinical management because patients fail to comply with an intervention. Of course, the alternative view is that clinicians fail to comply with individual (cultural) perspectives of the condition, but because the clinician has the power and the ownership of the condition their voice carries more weight than that of the patient. This of course is a double edged sword: the patient believes the clinician has the power to name and cure the condition but is at the same time powerless to understand the condition because the patient is unable, unwilling or incapable of sharing the same beliefs about the condition. This is entirely in the absence of the partner, who is either involuntarily or voluntarily absent from the discourses.

The reality of PE

There are multiple ontologies, i.e. many constructed realities, to explain PE, for example, the reality of having PE; the reality of the consequence of PE; the social impact of PE; and the medical/psychiatric discourses that explain and qualify the premature ejaculator. All of these must be included in seeking to answer the research question.

Multiple epistemologies

The knower and known interact and shape one another, but there are diverse and often contradictory messages and discourses about PE. The constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and subject create understandings), and a naturalistic (in the natural world) set of methodological procedures. It is therefore helpful to contextualise PE using *critical multiplism* (Miller and Crabtree, 2000). In addition, and particularly as a framework for analysing the qualitative arm of the trial, Foucault's Rules for Forming Discourse were deployed.

Foucault's rules for forming discourse are:

1) Surfaces of emergence: social and cultural areas through which discourse appears, e.g. the family, work, or religious groups. For premature ejaculation, many patients report that masturbation is haram (forbidden by Islamic teaching) whereas in reality it is not strictly prohibited, but rather can be used for treatment purposes.
2) Authorities for delimination: institutions with knowledge and authority, which for clinical management of premature ejaculation, is the clinic (whether medical or psychiatric)
3) Grids of specification: a system by which concepts can be linked to each other by discourse. This is particularly useful since there is a perception by many patients that masturbation causes premature ejaculation (Foucault, 1992)

The purpose of the research was to allow explanations of PE to be voiced by patients, who are traditionally marginalised from the literature (or even discounted) but these voices are relevant to the marginalised group that made up the participants (Bangladeshi Muslim men). The intention of the research was to make links between micro-processes, such as clinician-patient, and macro-structures, such as social relations, which Willig (2001) contends is the main advantage of this type of method, allowing capture of the subjective feel of a particular experience or condition.

Thematic Analysis

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data; minimally organising and describing data (Braun and Clarke, 2006). Thematic analysis can be applied to different theoretical frameworks, for example within an essentialist or realist method, which reports experiences, meanings and the reality of participants, and it is for these reasons that it has been adopted for this research. Braun and Clarke (2006) contend that thematic analysis can be a method that works both to reflect reality and to unpick the surface of reality.

Pre-requisites for thematic analysis

Clarification of terms

Data *corpus* refers to *all* data collected for a particular research project. This data is presented in chapter five and has been listed as descriptive data. This data includes demographic and stopwatch data that is not sufficiently meaningful to answer the research question. The data *set* refers to all the data from the corpus, which is being used for analysis. This data is recorded in chapter five under the sub-heading of qualitative descriptive results and it is from this data set that items (each individual piece of data collected) will be drawn for the subsequent thematic analysis.

For the purposes of this research, the corpus is the published literature and the narratives captured from the semi-structured interviews. The data set is drawn from Bangladeshi Muslim men, and the items are drawn from narratives that illustrate each major and sub-category theme.

The thematic analysis model

Before analysing the process in detail, it is essential to position the analysis within a conceptual framework, which in this case is Foucault's notion of governmentality and panopticism. Both concepts are discussed in greater detail in chapter three.

The themes did not emerge from the literature or clinic as preformed concepts. The themes became apparent from re-reading clinical research reports and through reflection of clinical practice. Once the themes were identified, a process of further reflection and analysis ensued. Each theme captured an important element of the clinical whole, for example, Waldinger's contention that use of stopwatches to objectively measure ejaculatory latency, was a recurrent finding in the literature, but in clinical practice terms, had little or no relevance to the man experiencing PE. From this, the theme of time was

identified. The details contained within the themes are discussed in chapter five.

What counts as a theme?

Some themes are more prominent than others, again an example here is time, which forms a point of tension for many of the commentators and indeed some patients in practice, but time is not the only or most important theme. The clinical space, definition, clinician/researcher and prevalence, all were important in the analysis because there were over-arching concepts within these. The weight given to each theme was dependent on its interrelationship with the clinical whole.

All data included or a defined aspect?

To contextualise the research, all clinical data has been included to allow for the entire picture of the clinical encounter to be seen. However, the data are very diverse and so the analysis has been separated between the clinical trial and the qualitative narratives, with the focus of the analysis confined to the qualitative narratives only. Triangulation between qualitative and quantitative data was performed.

Inductive or theoretical thematic analysis?

Braun and Clarke (2006) contend that there are two ways of identifying patterns or themes in the data, a bottom up inductive way or a deductive top-down way. Linking this with the theoretical framework, a top-down approach has been adopted, whereby the clinical problem has been viewed through the lens of governmentality and operation of biopower (from Foucault) and by exploring the medicalisation of sex (from Armstrong, 1987; and Nye, 2003).

Semantic or latent themes

Within a semantic approach to thematic analysis the themes are identified within the explicit meanings of the data, for example, the statement ‘I

ejaculate too soon' is a theme that is about time. Further questioning of a participant may reveal that he believes that normal ejaculatory latency is up to 30 minutes; again giving the main theme as time. With a semantic analysis, there is no looking beyond what this person has said, thus leading to a descriptive account of what PE means to that man. Within a latent exploration of the theme, there is an intention to look beyond the semantic level and to identify and examine some of the underlying assumptions of, in this example, time. An attempt has been made, where the data is rich enough to support it, to go beyond what has been said and to adopt a latent approach to the analysis. This has not always been possible, principally because the narratives are not always detailed enough to support this level of analysis. This lack of richness is attributable to two problems; the first is that most of the participants did not speak English as a first language, so nuancing was lost, and secondly because the same participants were reluctant to engage further with questions about their feelings. A marked mind/body separation was evident, and this is discussed in later in the thesis.

Epistemology: essentialist/realist or constructionist thematic analysis?

This aspect of the model proved to the greatest difficulty in relation to the analysis. An essentialist/realist approach looks to theorise motivations, experiences and meanings in a straightforward way, in a unidirectional manner (unidirectional because as the clinician/researcher I was explicitly in a position of unidirectional power). From a constructionist perspective, meaning and experience are socially produced and so there is no focus on the individual motivations for seeking help, but rather a theorisation of the sociocultural contexts and structural conditions that enable the individual to speak. As Braun and Clarke (2006) indicate, thematic analyses focussing on latent themes tend to be from a constructionist perspective and overlaps with thematic discourse analysis. The constructionist perspective has been adopted in this research.

Qualitative data analysis

A detailed description of how the thematic analysis was undertaken, drawing on the model proposed by Braun and Clarke (2006). Their sub-headings have been used to structure this part of the thesis. An overview of the model is shown in table 4.3.

The six stages of thematic analysis

Table 4.3 Phases of thematic analysis (Braun and Clarke, 2006)

Phase	Statement	Description
1	Familiarising yourself with the data	Transcription of data, reading and re-reading data; noting ideas
2	Generating initial codes	Coding interesting features in a systematic fashion across the entire data set
3	Searching for themes	Collating the codes into potential themes
4	Reviewing the themes	Checking the themes work; generating a thematic map of the analysis
5	Defining and naming the themes	Ongoing analysis to refine the specifics of each theme
6	Producing the report	Final analysis, relating back to the literature and research question

Phase 1 Familiarising yourself with the data

A schematic model of all the aspects that seemed relevant and important to the patients was developed from clinical experience of treating Bangladeshi men for PE. Most patients are drawn from a community where between ¼ and ½ are Bangladeshi Muslims. Reflecting on the clinical encounters, a schematic was devised that illustrated all of the issues that seemed to be important to these men, or rather the issues that seemed to be repeatedly referred to by men attending the clinic.

Following on from the schematic, a literature review was undertaken to identify themes or issues that were commonly reported. Both clinical

experience (refer to figure 4.3) and the review of the literature (refer to figure 4.4) led to the initial indication of core themes, but the research was not explicitly designed to look for the themes that had been identified.

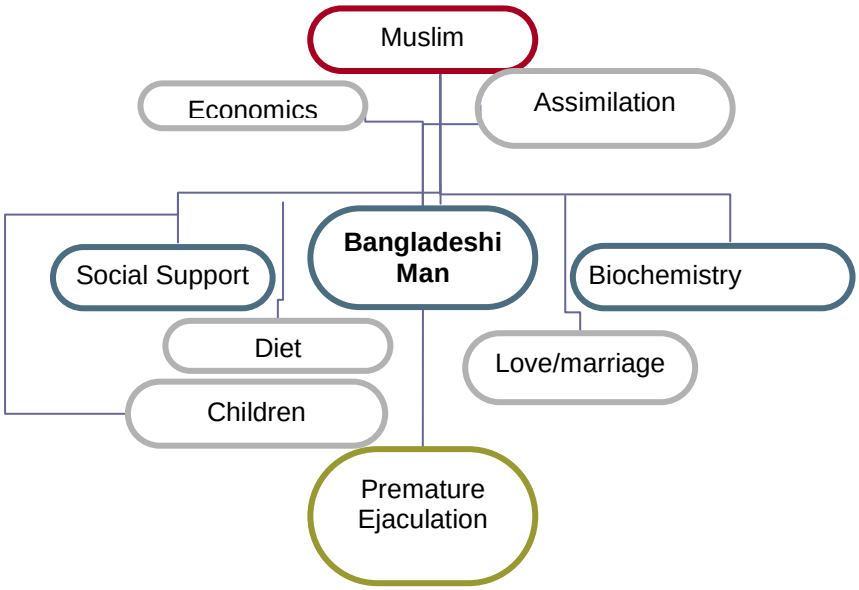


Figure 4.3 Patient theme map (from clinical practice experience of treating Bangladeshi Muslim men).

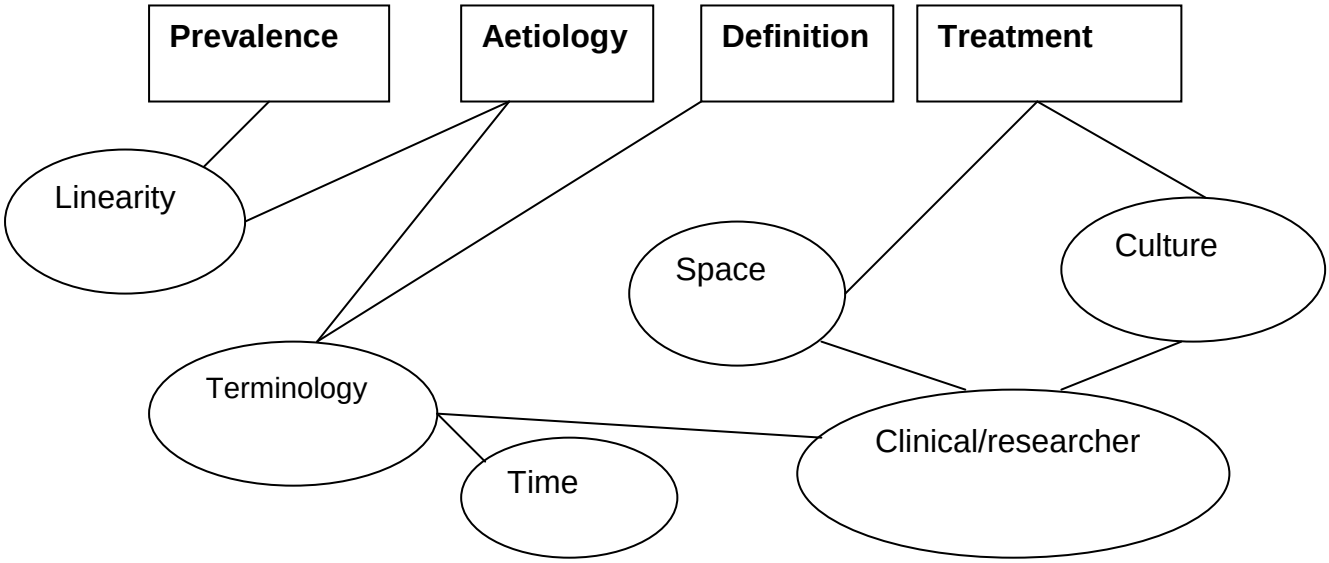


Figure 4.4 Literature review theme map

The research involved answering a schedule of semi-structured questions (refer to appendix six). These responses were then immediately transcribed from the clinical research notes to a blank research file. Each file had the semi-structured question at the top of the page and each transcribed narrative was recorded. This was a key part of the analysis since it allowed familiarisation with the data, as suggested by Riessman (1993). In addition to reading and re-reading the transcripts, an attempt was made to interpret the meanings embedded in the transcripts and to explore these further by noting the physical environment in which the encounters were undertaken and the pauses/non-verbal actions that each participant used.

Phase 2 Generating initial codes

From phase 1, and the initial review of the literature, a list of possible ideas about the quality of the data, and what was of interest in the data was obtained. From this codes were identified that explored a particular feature of the data. Miles and Huberman (1994) suggest that the process of coding is part of the analysis as the data is being organised into meaningful groups. The coded data (refer to the qualitative results analysis) is different from the themes, which are broader. Each data set was reviewed time and again, and discussed with my clinical colleagues who also saw men with PE, to ensure that the codes were given equal weighting. The data was coded manually but the data from which the codes were drawn were kept together, allowing the context in which the narrative was placed to be preserved. Some of the data fitted more than one theme and some repetition of the data set occurred.

Phase 3 Searching for themes

After coding and collating all the codes, the codes were sorted into respective themes and sub-themes. An initial thematic map was developed (refer to figure 4.5) and the relationship between codes was identified. At this point, there were main themes and sub-themes, as well as some codes that did not appear to fit into any theme or sub-theme. From this point, the main themes and sub-themes were identified.

Initial thematic map

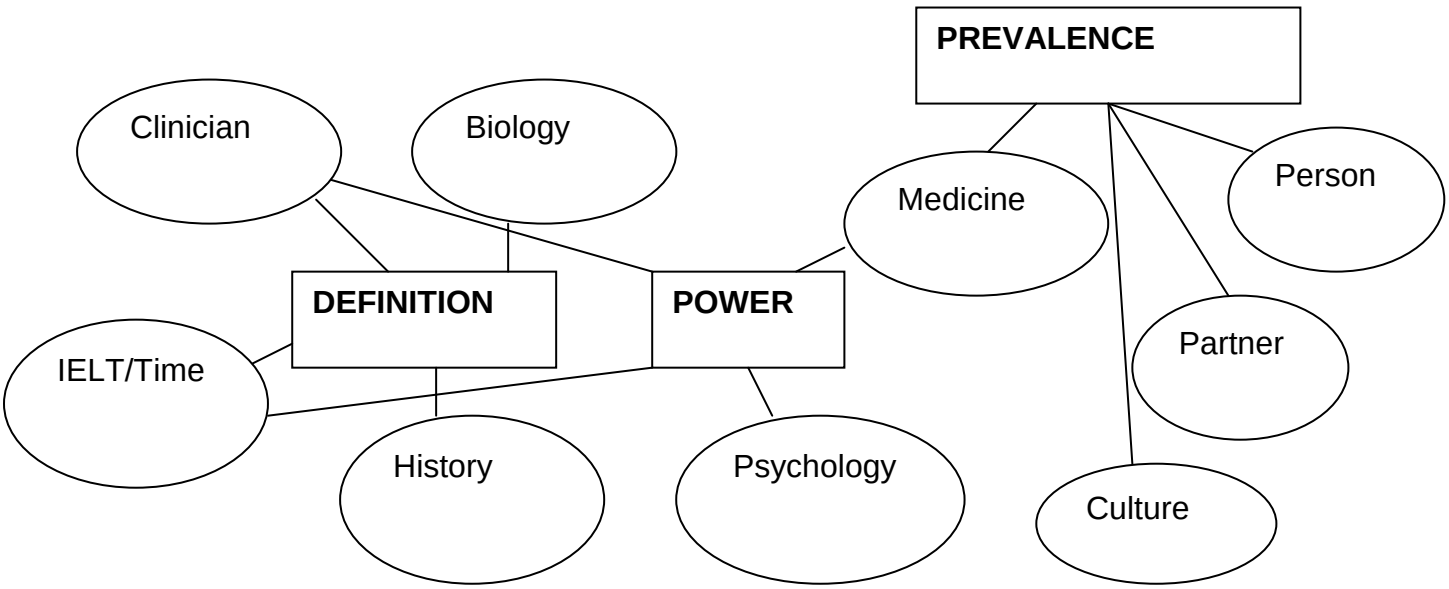


Figure 4.5 Initial thematic map

Phase 4 Reviewing the themes

This is the phase where refinement of the themes occurred. Initially the coded data extracts were reviewed, which Braun and Clarke (2006) refer to as level one analysis. From this point, a candidate thematic map was drawn (refer to figure 4.6) and the analysis was undertaken again but by reflecting on the credibility and trustworthiness of each theme. This was further enhanced by a research assistant independently identifying the same candidate thematic map. The final part of this phase of the analysis was the production of the definitive themes and sub-themes.

Candidate thematic map

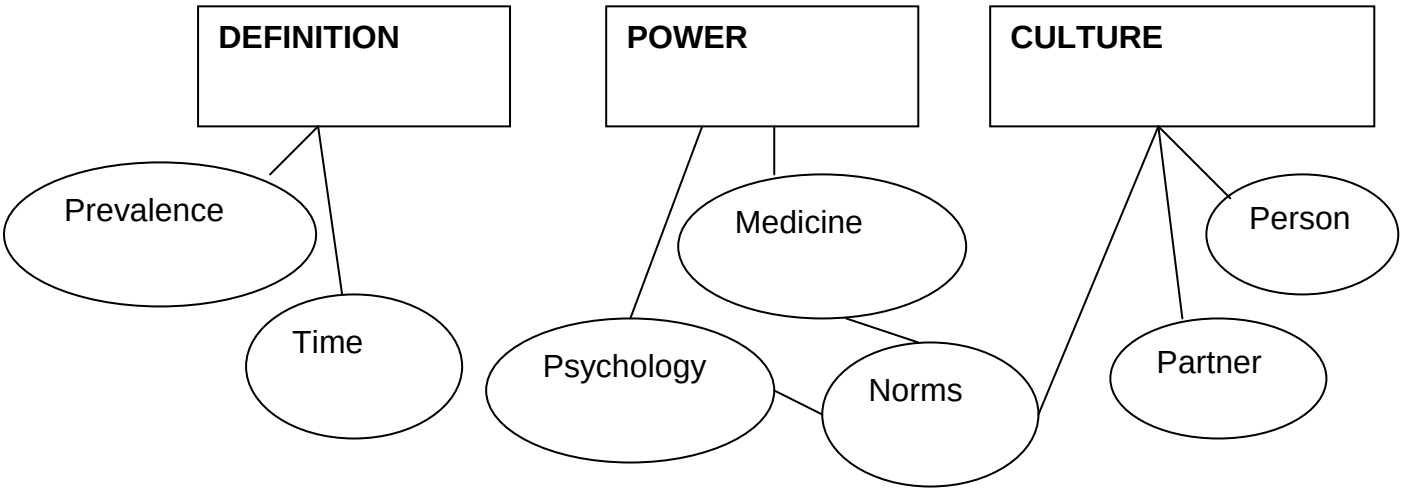


Figure 4.6 Candidate thematic map

Phase 5 Defining and naming the themes

In this phase, the themes were defined by analysing all the factors that were important in that theme, effectively summarising the data that had been generated and interpreting the meanings within it. Each theme was linked together, allowing a coherent picture of the whole of the thesis to become clearer (refer to figure 4.7).

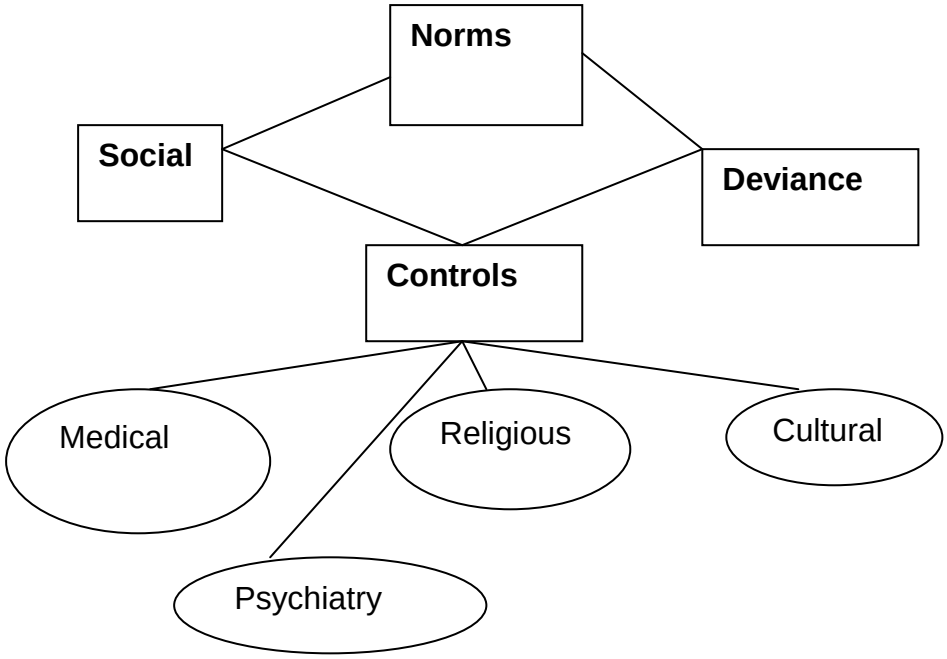


Figure 4.7 Predominant themes

From figure 4.7, the final thematic map was generated (figure 4.8). The main themes generated were biomedical, cultural and psychological. These can be summarised as:

a) The medical theme – medical definition and use of time as an objective measure normalises sexual activity. Published literature and participants make sense of the dysfunction by drawing on time as an end-point to satisfactory sexual activity. Time as a measure however is problematic, as there is no measure of accurately establishing when sexual desire began, which will influence ejaculatory latency. Time forms part of all definitions (approved biomedical and psychiatric as evidenced by the DSM-IV criteria), and by participant and partner expectations.

b) The psychological theme – an apparent separation between mind and body, evidenced by published literature and participants responses repeatedly reinforcing the mind as machine metaphor. Very few participants indicated their need for a mutually affirming sexual life; many also reported an absence of intimacy outside of sexual intercourse. This finding is key because of the

attendant pressure to perform during sexual activity. For the female partner, the only physical contact was during intercourse, making this activity desirable in terms of physical closeness. This finding requires further research to analyse it properly.

c) The cultural theme – constructions of what constitutes normal sexual behaviour and how these norms have developed. Both published literature (refer to the history of masturbation) and participants' responses illustrate the construction of normal and acceptable sexual activity. Little or no sexual education was apparent in the participants narrative experience, with many participants indicating that discussions about sexual activity are haram. Partners were absent from discussions, indicating that the Bangladeshi Muslim women were culturally constrained and therefore unable to engage in discussions/treatments related to sexual activity. A possible explanation for this is not related to religion at all; individuals simply use this as a mask to hide their embarrassment or unwillingness to engage in a therapy that they don't perceive as being what they need.

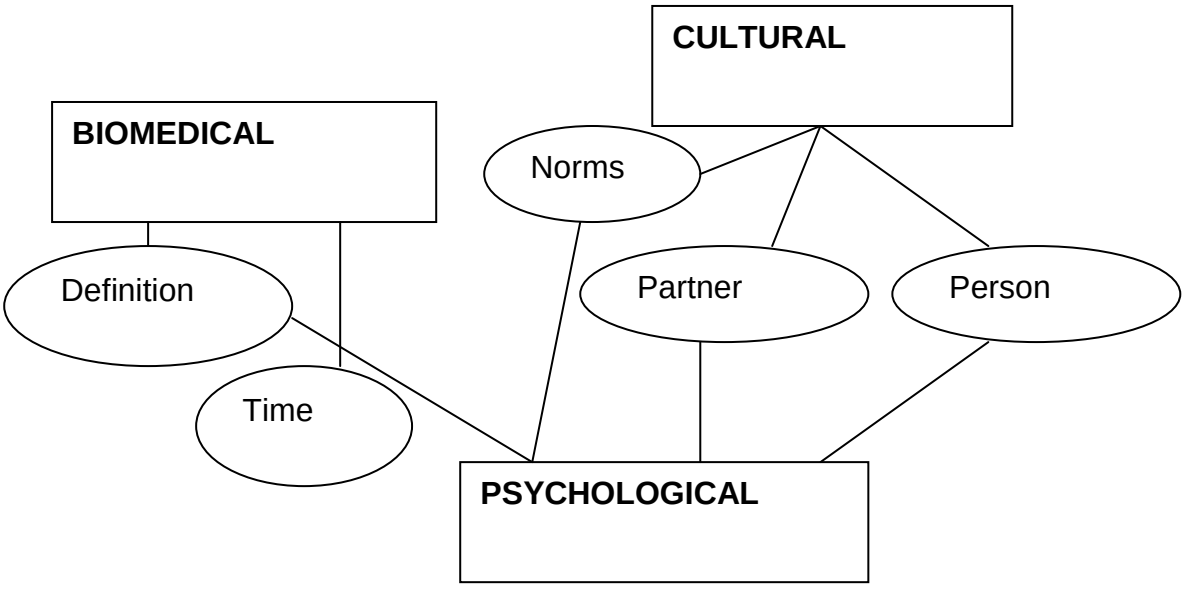


Figure 4.8 Final thematic map

Phase 6 Producing the report

The production of the final report is, in essence, this thesis. Chapter five discusses both the descriptive and interpretative data. At the end of the chapter is a summary analysis which includes statements about each theme and the evidence that supports these statements.

Foucault and Thematic Analysis

Foucault discusses discourse and ways in which conditions come into being, requiring categorisation of a section of the population. So a premature ejaculator comes into being, by meeting the diagnostic criteria with, in some cases, inclusion of an IELT measure. Discourses do not simply describe the social world, but categorise it. They bring phenomena into sight, or as Parker (1992: 15) suggests, 'discourses allow us to see things that are not really there, and that once an object has been elaborated in a discourse, it is difficult *not* to refer to it as if it were real'. In this case PE being categorised into lifelong, acquired, primary or secondary, plus the addition of IELT measures or the counting of the number of thrusts, etc. are the objects of the discourse.

Discourses are defined as 'sets of statements that construct objects and an array of subject positions' (Parker, 1999: 245) and these constructions, in turn, make available certain ways of seeing the world and certain ways of being in the world, offering *subject positions*, which, when taken up, have implications for subjectivity and experience. In premature ejaculation there are three main discourses and subject positions, biomedical, psychological and cultural, each with recurrent sub-themes of definition, time, and space.

Foucauldian analysis is concerned with language and its role in the constitution of social and psychological life. Parker (1992) suggests that discourses facilitate and limit, enable and constrain what can be said, by whom, and in what circumstances. These have been alluded to within Foucault's rules for forming discourse. However, explicit interest with the role of discourse in wider social processes of legitimation and power need to be

included in the analysis, since the clinical encounters are influenced by many sources of knowledge and power. Discourses make available ways of seeing and ways of being, and are strongly implicated in the exercise of power. Dominant discourses privilege versions of social reality, which legitimate existing power relations and social structures. There is a strong biomedical discourse in the legitimising of PE. As mentioned previously, men with PE need to confess the condition in the clinic, and are defined by certain parameters, such as the DSM-IV criteria, use of a chronometer, etc.

Since biomedical and psychological discourses are so powerful in Western healthcare practice, it was essential to include historical perspectives in relation to sexual activity and explore the ways in which various discourses have changed over time, and how this may have shaped historical subjectivities (see also Rose, 1999). Of course, cultural discourses are also prevalent but are much more difficult to capture in terms of reviewing literature; where possible, cultural discourses on sexuality (whether historical or contemporary) have been included to offer textures to the analysis. Finally, the analysis also pays attention to the relationship between discourses and institutions. Here, discourses are not conceptualised simply as ways of speaking or writing. Rather discourses are bound up with institutional practices – that is, with ways of organising, regulating and administering social life. Therefore, while discourses legitimate and reinforce existing social and institutional structures, these structures, in turn, also support and validate the discourses. This is clearly exemplified by the PE clinic: being positioned as ‘The Patient’ within a biomedical setting means that one’s body becomes an object of legitimate interest to clinicians, in that it may be exposed, touched and invaded in the process of treatment which forms part of the practice of medicine and its institutions (i.e. the clinic).

Foucauldian analysis is also concerned with language and language use, however, its interest in language takes it beyond the immediate contexts within which language may be used by speaking subjects. Foucauldian

analysis asks questions about the relationship between discourse and how people think or feel (subjectivity), what they do (practices) and the material conditions within which such experiences may take place. In the research, discourse from semi-structured interviews were considered as a suitable means of gaining data that can be interpreted to uncover the textures and meanings that PE has for these men.

Transcripts were read and re-read repeatedly during the process of analysis to provide further evidence to support or challenge emerging themes, for as Parker (1992) suggests

> 'language…can help us reflect what we do when we speak (or write)' (Parker, 1992: 20)

This would indicate that interpretation of the language used may be different depending on the perspective of the reader and therefore an independent analysis was completed by a research assistant. Discrepancies in the coding were then discussed and an agreement reached on location of the discourse (i.e. whether biomedical, psychological or cultural). The discourses are bound up with history, both in the sense that people have discourse now at this point in history (here people feel the weight of the past), and in the sense that politics and power are about the ability to push history in particular ways (there people construct a hope for the future) (Parker, 1992) and the differences between discourses is aggravated as one discourse is employed to supersede the other. By this a discourse alludes to collision. Firstly, there is the discourse of the man with PE – he is unsure what the cause of this problem is but hopes for physical causation because there is then a physical (or pharmacological) solution. The clinician, by contrast (although one should accept that the clinician perspectives are by no means universal), looks for causal factors for the condition, for example, loss of intimacy, infrequent sexual activity, neuro-chemical alteration, and various other explanations (it is also interesting to note here the usage and meaning of the word 'other'). Treatments are then offered based on observations, clinical experience, the

organisational culture of the clinic, and patient engagement with any programme.

The advantage of using thematic analysis to approach the analysis is that as Parker (1992) contends ‘it reframes the object, and allows us to treat not as truth, but as one truth held in place by language and power’ (Parker, 1992: 35).

Having described and reflected on the analytic method, a description of how the research was conducted, the location, and who gave informed consent to participate is addressed.

Summary

This research constitutes a first level descriptive exploratory design using thematic analysis to identify patient concerns about PE. The rationale for this approach is that no real in-depth exploratory research has been done in this area, with most of the clinical reports focussing on quantitative methods and subsequent analysis. Acknowledging Waldinger’s (2003) contention about the need for evidence-based medicine approaches to treatment of PE, it is my contention that sexual activity should be beyond the scope of evidence-based medicine and that sexual activity should remain meaningful to only the participant and his partner at a particular moment in time.

The next chapter is the results of the research.

Chapter 5

Results: Quantitative and Qualitative Discourses Within the Corpus of PE

Introduction

The presentation of the results serves two purposes; the first is descriptive and the second is analytical. For clarity, each response was grouped into categories, where possible, to illustrate the range of responses from Bangladeshi Muslim men. The data presented is entirely from this group and the motivation for this is to partly redress the balance in the literature that ignores or marginalises this group, and partly because this group represented the majority of participants in the research. The results do not intend to represent all Bangladeshi Muslim men, just those from East London who agreed to participate in the research, and should not be generalised to a wider population. The results shed light onto a group absent from the literature, but are limited to those motivated to enrol in the research. As noted previously, only the most motivated of individuals form part of sex research trials (Steggall, et al. 2008), and therefore a cautious approach should be taken when interpreting the results. In part one the quantitative results are presented, albeit grouped round specific responses. In part two the qualitative data are analysed, consolidated and grouped into the predominant themes (biomedical, psychological, and cultural).

Descriptive data – the Bangladeshi participants

23 Bangladeshi Muslim male participants provided self-report ejaculatory latency estimation and stopwatch-assessed ejaculatory latency times (refer to Figure 5.1).

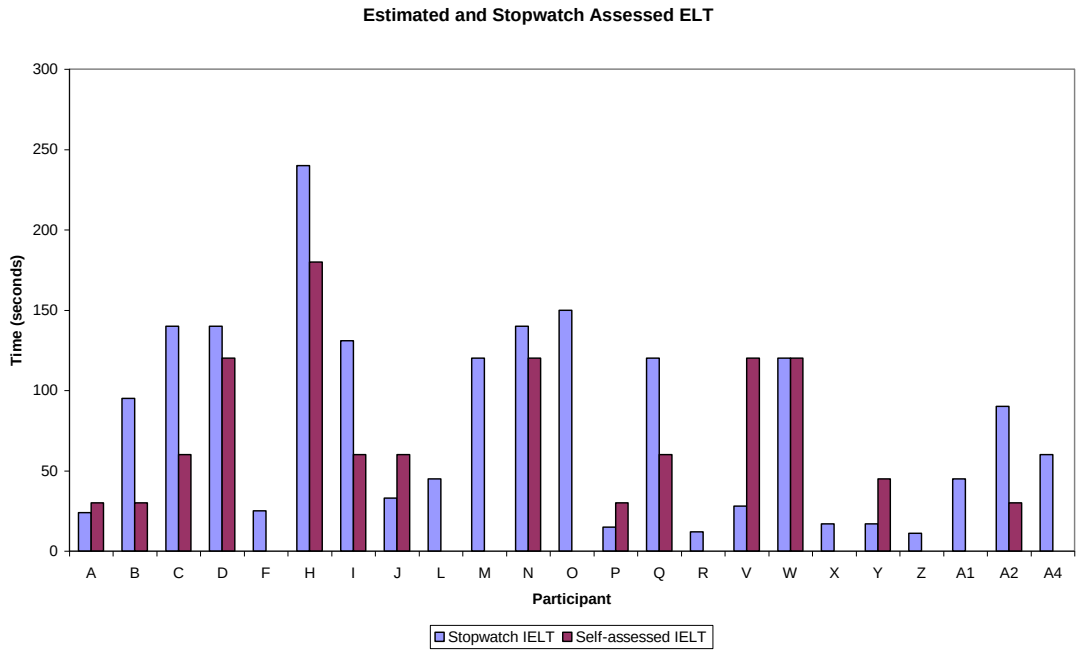


Figure number 5.1 Stopwatch and estimated ejaculatory times

The mean self-assessed ejaculatory latency time (ELT) was 46 seconds and the mean stopwatch assessed ELT was 79 seconds. Participant H had an ELT of > 4 minutes but still believed that he had premature ejaculation. If the obvious outliers are excluded from the analysis of mean, i.e. participants B, C, H, I, M, O and A2, stopwatch assessed ELT becomes 53 seconds and self-assessed ELT becomes 44 seconds. What this indicates is that, if comparisons of means are used to explore ejaculatory delay, it would indicate that men are able to determine reasonably accurately, their own ejaculatory delay. However, reviewing the histogram illustrates that very few men were able to estimate their ejaculatory delay accurately. Only participants A and P achieved this. This raises two interesting questions. The first is whether time is actually a matter of importance for the man (or his partner) with PE, and the second is if time is not easily estimated, does use of a stopwatch really objectively measure ejaculatory latency, or in other words, to what extent does the man with PE accurately measure his latency time using a stopwatch? Both of these points will be further discussed later as they form part of the theme dealing with biomedical discourses.

The mean age of the Bangladeshi Muslim patients was 40 years (range 25 to 59) and the participants had no pre-existing physical or diagnosed psychological problems. Jannini, et al. (2005) contend that there is an association between social class, educational attainment and PE, although the relationship has not been analysed or theories developed to account for this finding. The participants in this research were in either low-paid occupations or not working (n=21), with only 3 participants in Social Class 2 or above (refer to table 5.1 for participant's demographic details). However, the opportunities for work in the East End of London are not high, particularly if command of written or spoken English is poor, and therefore the social class of these participants neither confirms nor refutes Jannini et al's (2005) observations. Beck, et al. (2005) identified that Bangladeshi immigrants face socioeconomic depravation, and cultural factors, underpinned by economic and social inequalities, have a marked (negative) impact on sexual behaviours and access to treatment.

The number of sexual partners and number of children have been included here to illustrate pertinent social features in the participants. These features also include lack of sexual experience (evidenced by number of sexual partners) and pressure to produce children (usually fairly early on in their married lives).

Participant	Age	Type of work	Type of marriage	Number of sexual partners (lifetime)	Number of children
A	43	Waiter	Arranged	1	2
B	41	Waiter	Arranged	6-10	4
C	25	Sales Assistant	Arranged	1	0
D	37	Phlebotomist	Arranged	1	0
E	32	Waiter	Arranged	1	1
F	47	Not Working	Arranged	1	6
H	53	Engineer	Arranged	1	2
I	30	Lecturer	Love	2-5	1
J	34	Waiter	Arranged	6-10	1
L	36	Truck driver	Arranged	2-5	4
M	59	Not Working	Arranged	1	5
O	53	Not Working	Arranged	2-5	0
P	37	Not Working	Love	>20	3
Q	35	Not Working	Arranged	1	6
R	40	Businessman	Arranged	2-5	2
S	28	Care Assistant	Arranged	1	0
V	38	Banking Advisor	Arranged	2-5	4
W	31	Sales Assist	Arranged	1	1
X	42	Driver	Arranged	2-5	4
Y	50	Not Working	Arranged	1	4
Z	31	Self-employed	Love	1	2
A1	39	Not Working	Arranged	2-5	3
A2	46	Waiter	Arranged	2-5	2

Table 5.1 Demographic information on Bangladeshi Muslim participants

Qualitative descriptive results

All patients were asked the same set of questions but any additional comments that participants made were recorded as obiter dicta statements and either transcribed during the consultation or immediately afterwards. Each participant was allocated a unique identifier code (Participant A, Participant C, etc.). Participants names were not used for two reasons, the first to preserve anonymity, which was very important for Bangladeshi men where being known as a premature ejaculator would be socially stigmatising, and the

second was because of commonality in names, for example, Muhammed/Mohammed, Ali and Uddin were frequently occurring names.

The main themes in the discourses were grouped into those dealing predominantly with discussions related to biomedicine, psychology and culture. Each of these had sub-themes, for example, time, definition, prevalence, treatment, etc. and one of the challenges encountered in reporting these results was one of presentation and remaining faithful to the importance that individuals attached to their narratives, but at the same time showing the variation in the responses. To achieve the former, the responses were grouped into common phrases or timeframes. These have been distilled into data tables. The advantage of this format of presenting the results is that both the range of responses *and* the numbers of participants who shared the responses can be easily seen. The drawbacks of such presentation are that the responses appear reductive and uni-focussed, and so interspersed within this chapter are mini-analyses and summaries of salient points. The first section of this results chapter therefore deals with the tabulated results and the second section of the results chapter is more analytical, seeking to explore some of the similarities and contradictions contained in the narratives. The chapter is concluded by recording the key theme summaries (biomedical, psychological and cultural), which serve as the basis for the Discussion chapter, where a more detailed discussion of problem spaces as a means of categorisation is provided.

Part 1

Tabulated responses

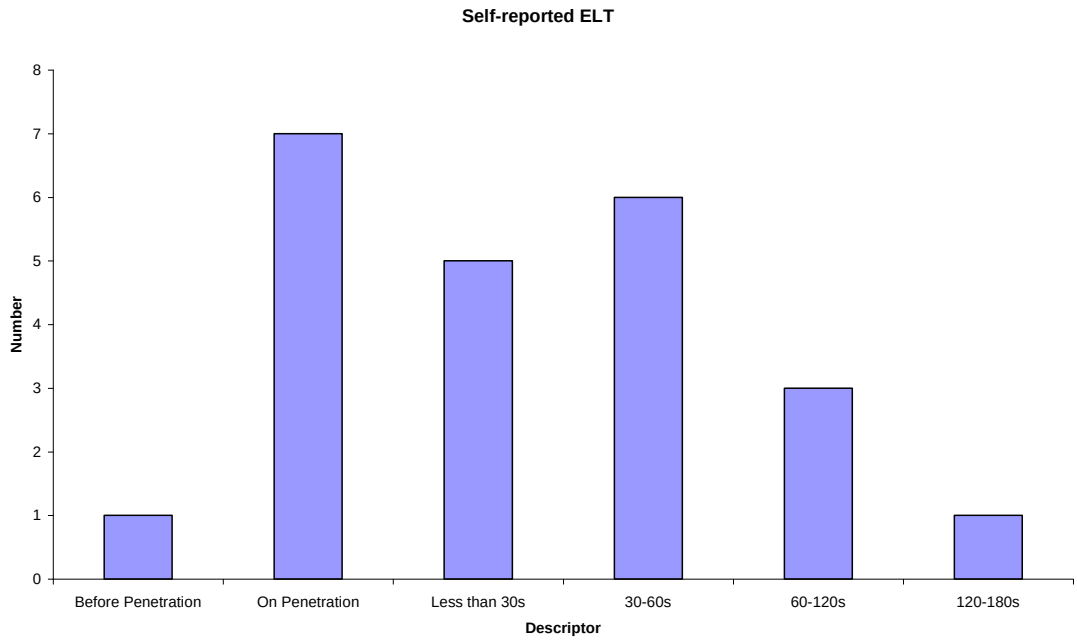


Figure 5.2 Self reported Ejaculatory Latency Time (ELT)

74% of the participants had acquired PE.

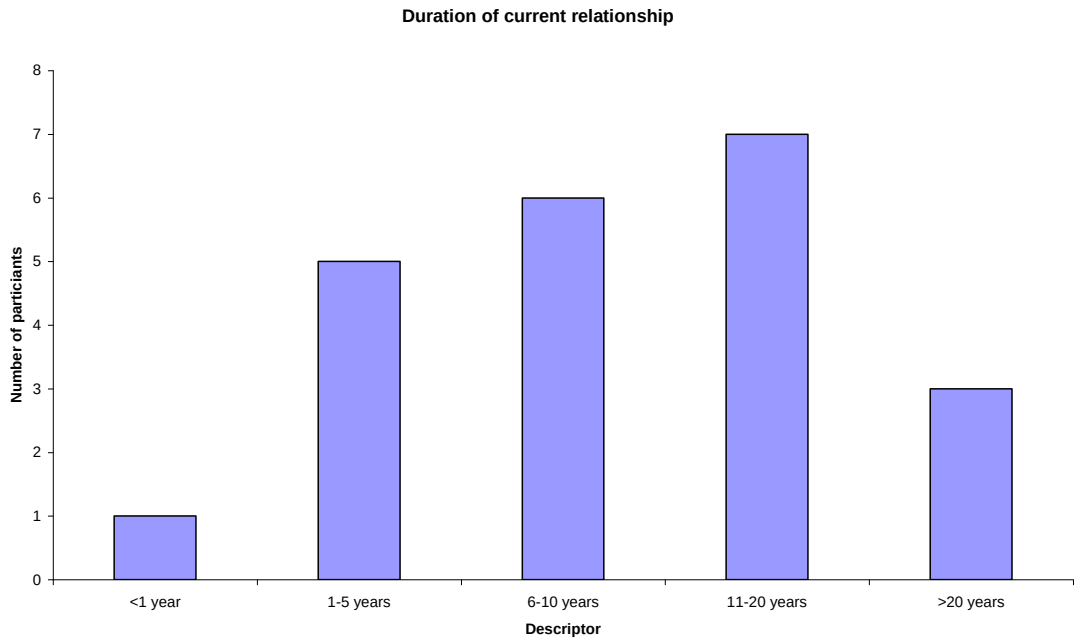


Figure 5.3 Duration of relationship

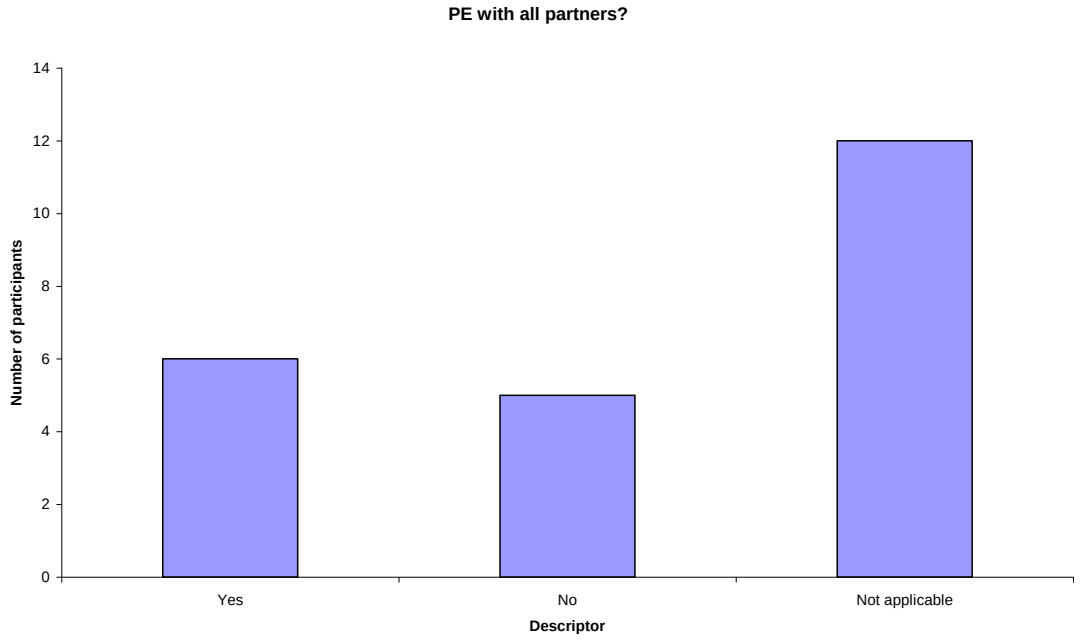


Figure 5.4 Did you have PE with all previous partners?

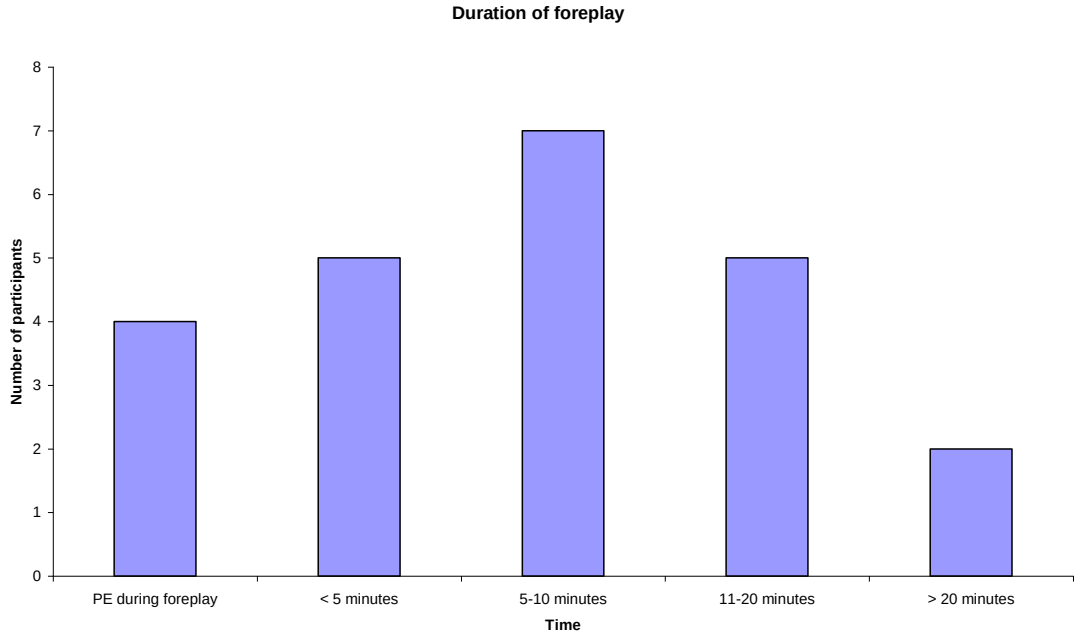


Figure 5.5 Duration of foreplay

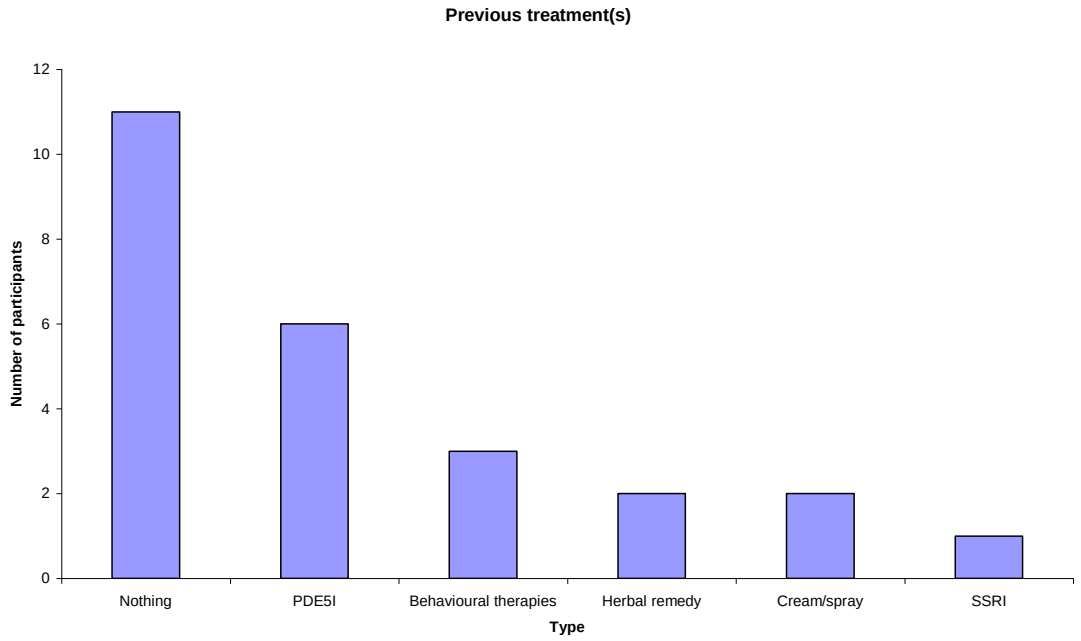


Figure 5.6 Previous treatments

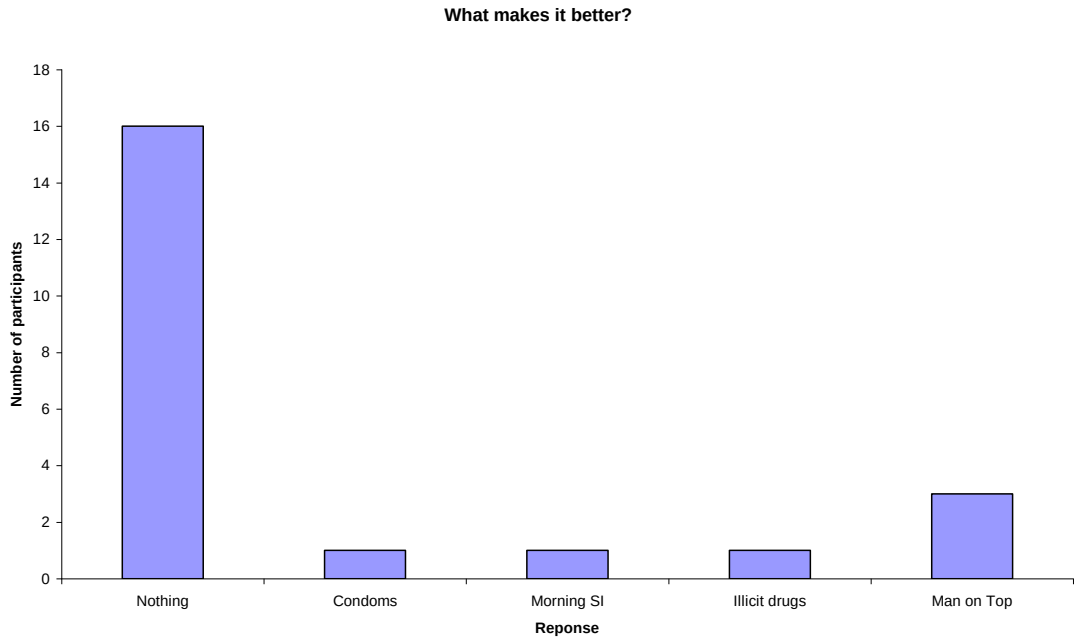


Figure 5.7 What makes it better?

Does your wife complain of pain when you have sex?

All said No

Is your wife (partner) fit and well?

All said Yes

13% had regular nocturnal emissions (wet dreams).

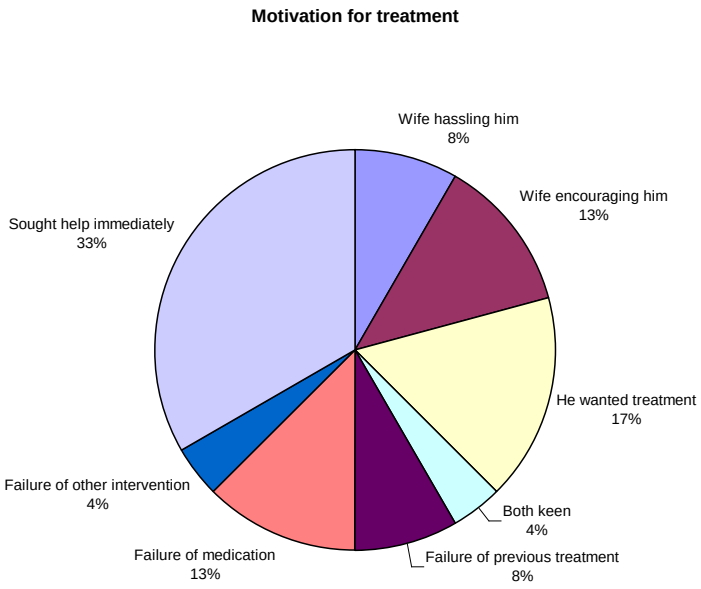


Figure 5.8 What/who made you seek treatment now?

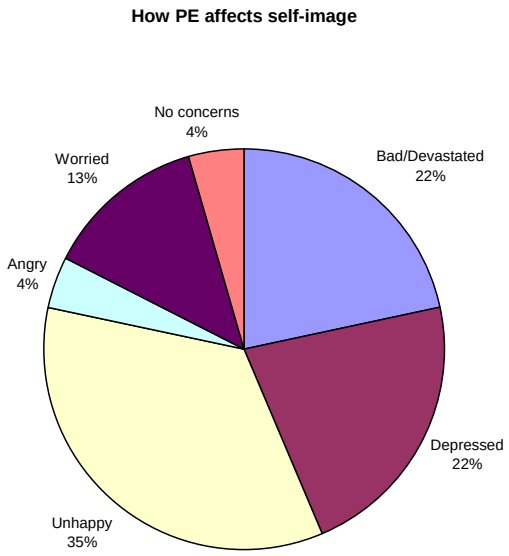


Figure 5.9 How does PE affect how you see your self/role as a man?

Do you have privacy when engaging in sexual activity?

All confirmed that they did have their own space in which to engage in sexual activity.

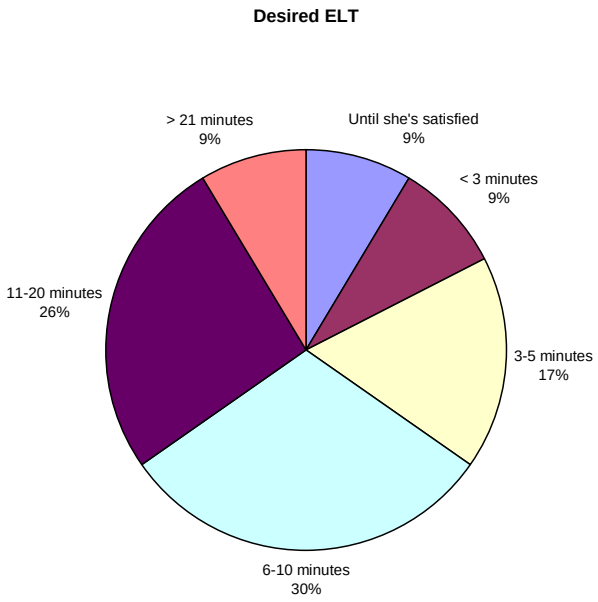


Figure 5.10 How long should you last?

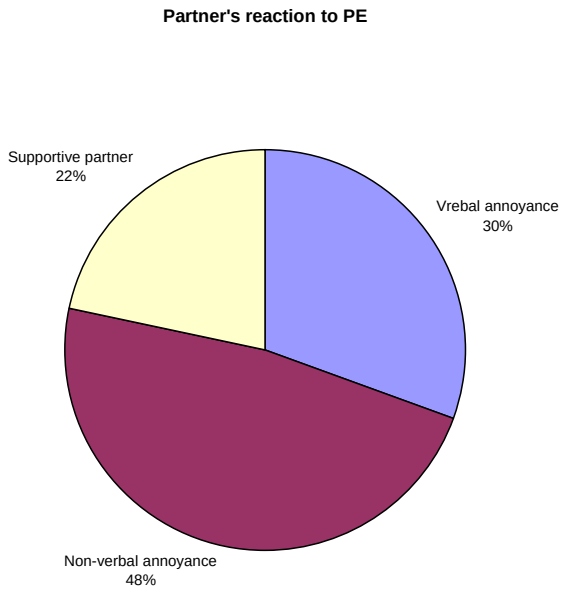


Figure 5.11 How does your partner view the problems you have with ejaculation?

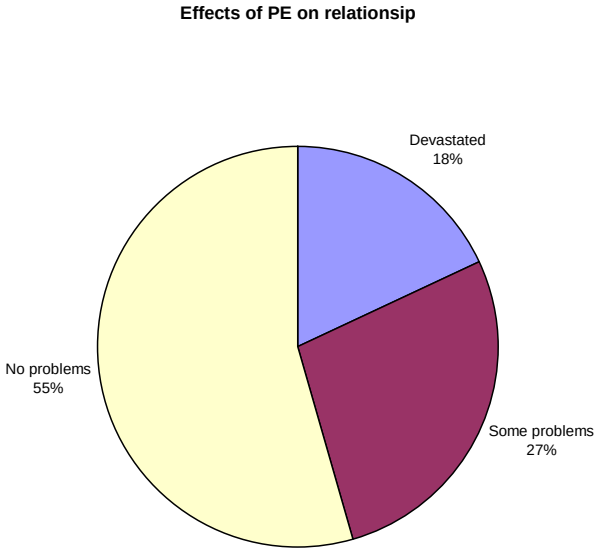


Figure 5.12 How does PE impact on your relationship generally and sexually?

83% of Bangladeshi participants had arranged marriages (with the partner coming from the home country).

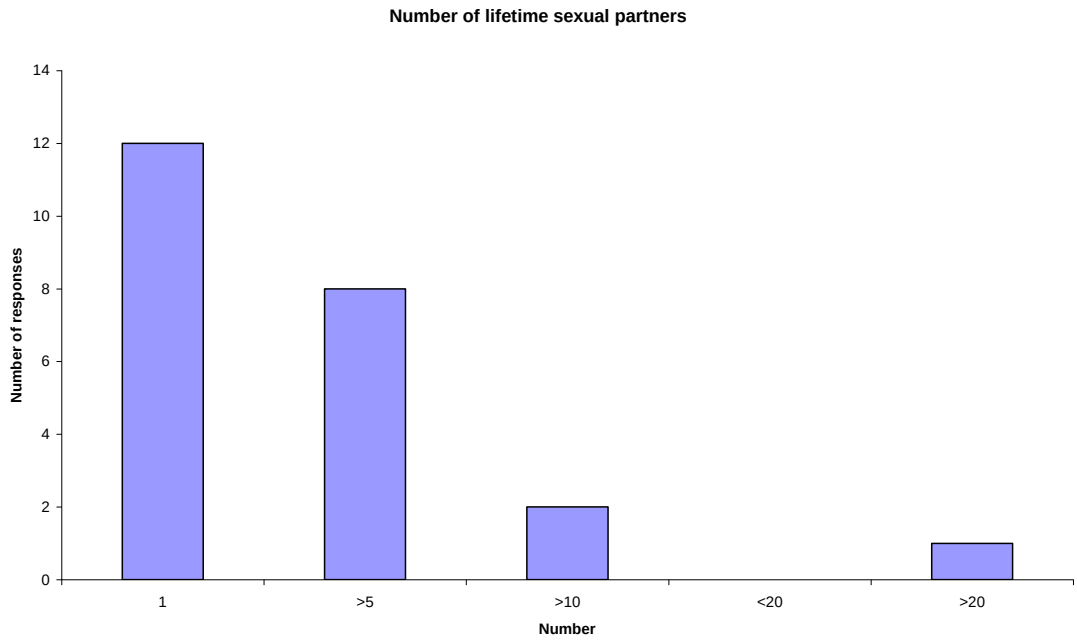


Figure 5.13 How many sexual partners have you had in your lifetime?

87% of participants did not have pre-marital sexual activity with their current wife.

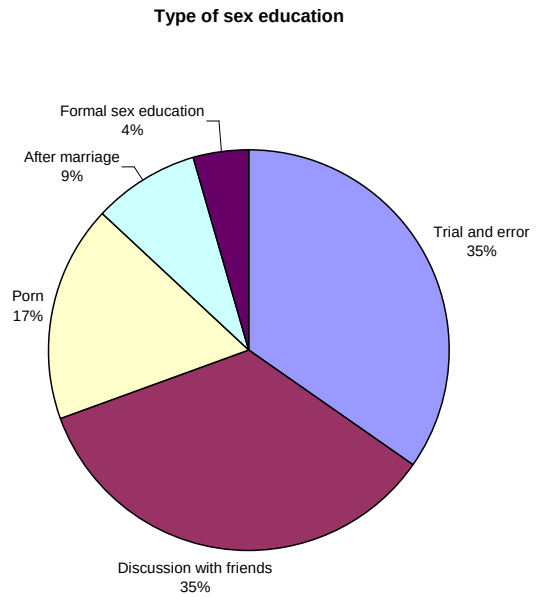


Figure 5.14 How did you learn about sex?

48% of participants stated that they could only engage in man-on-top sexual

intercourse. Participant W stated ‘it is always man on top – it is not acceptable [Islamically] for the female to be on top’.

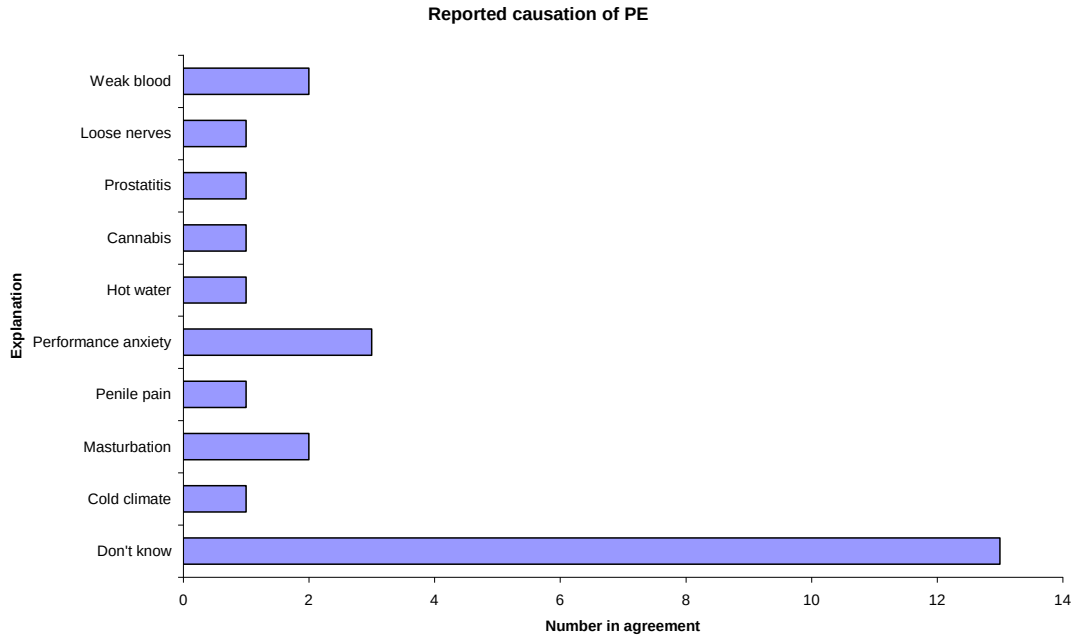


Figure 5.15 What causes the problem? (multiple responses)

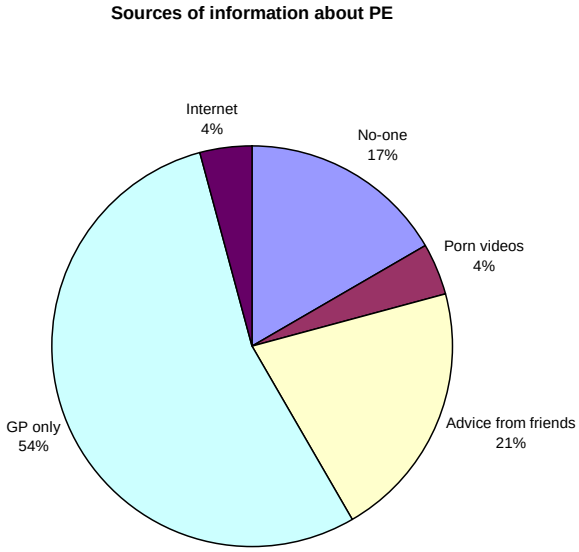


Figure 5.16 Have you sought information about PE from any other source (friends, family, Internet, etc.) Sources of lay knowledge

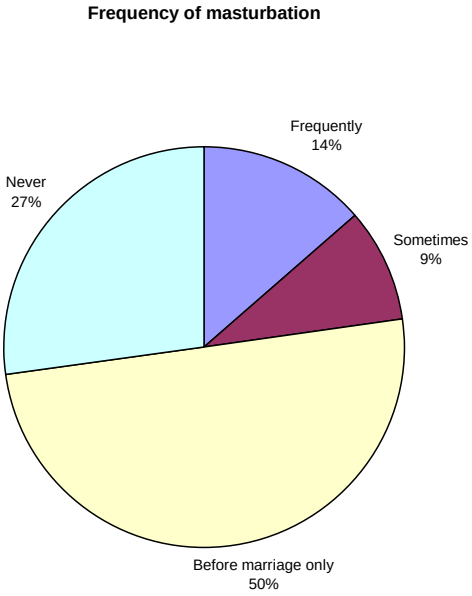


Figure 5.17 How often do you masturbate?

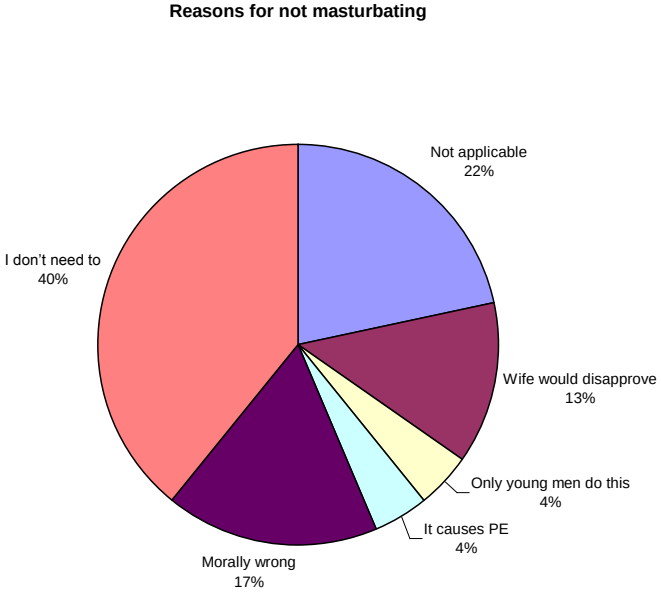


Figure 5.18 Why don't you masturbate?

Part 2

The tabulated descriptors are grouped into the identified themes, following the method suggested by Braun and Clarke (2006). The final set of themes (refer to Figure 5.19) were biomedical, psychological and cultural, but each theme had sub-themes that crossed each of these. The sub-themes are time; treatment; definition, norms; partner's perceptions; and the man's (person) perceptions of the consequences of PE.

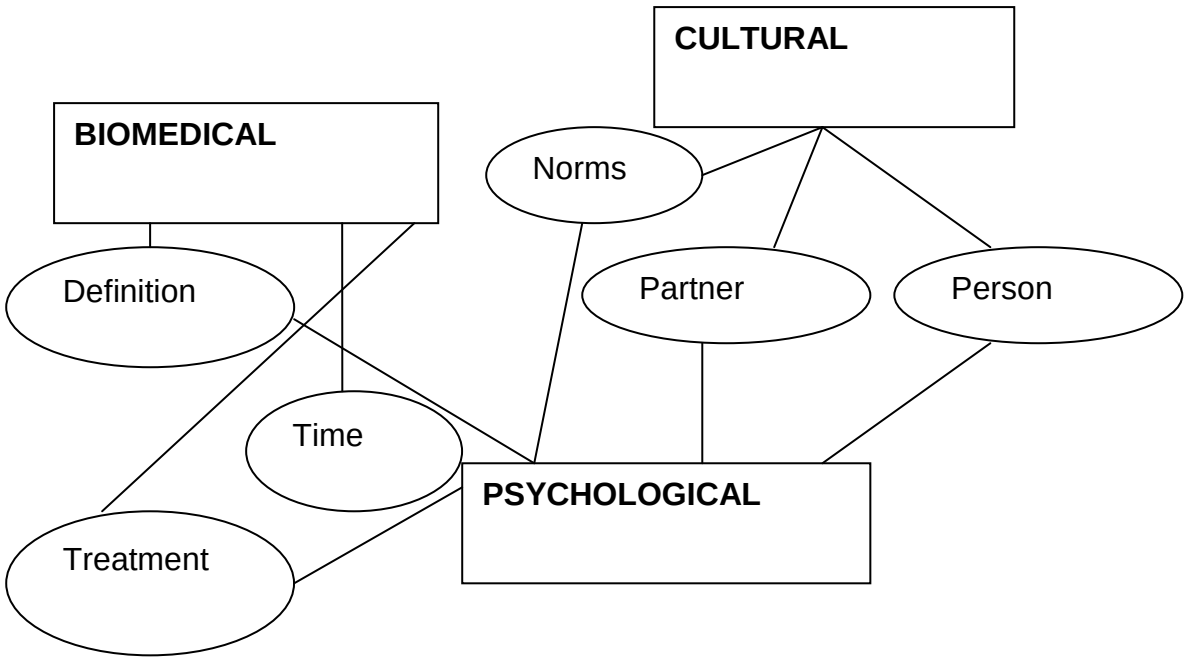


Figure 5.19 Final thematic map

Results analysis

Acknowledging that these themes overlap to some degree, they have been separated out and grouped around the main themes. There are two sets of themes, the themes identified from the literature review and themes from the patients who participated in the research. The similarities and contradictions between the participants and the literature will continue to be analysed in the discussion section. There will be an exploration of the dichotomy between published literature and the themes that are concerned with time, definition, prevalence and aetiology, which are predominantly from a biomedical

discourse, and the themes from participants in the research, who believe that they have PE. These results introduce narratives that are missing from the literature.

Biomedical discourses

Narratives included in biomedical discourses are self-reported ELT; whether acquired or lifelong PE; duration of relationship; PE in all situations or not; duration of foreplay; expectation of normal ELT; treatments used; what makes it better or worse; and presence or absence of nocturnal emissions.

PE is variously defined in the literature on the basis of time: 1 to 7 minutes after penetration, 8 to 15 thrusts, or when the man cannot delay ejaculation on 50% of occasions (Jannini, et al. 2007). Jannini, et al.(2005) stratified the time taken for ejaculation into severe (IELT less than 15s), moderate (when IELT is < 1 minute) and 'mild' when IELT is < 2 minutes.

Patient self-report of PE and self-estimation of ELT has traditionally been treated with caution by practitioners because the estimation of ejaculatory latency by men (and women) has correlated poorly with stopwatch-recorded ELT (McMahon, 2007). However, Pryor, et al. (2005) reported that patient self-estimation of ELT correlated reasonably well with subsequent stopwatch ELT, although the results of this research neither confirm nor refute this finding. There may be a difference in accuracy of self-report between those who claim to have acquired PE and those with lifelong PE, but what is clear from the data in this research is that there remains a subjective experience of PE; confirming or refuting this experience by using a stopwatch is not accorded value by the participant/patient with PE. Furthermore, in situations were PE is causing interpersonal distress, the inclusion of a stopwatch was the final straw (or excuse?) in the breakdown of the relationship, illustrating that simple time measures are not quite as important as the biomedical literature on research methods indicates.

The predominant discourse in understanding PE from a biomedical perspective was by referring to a measure of time as a primary outcome in the satisfaction of sexual encounters, or in other words, it wasn't the experience of the sexual encounter that was important, it was the time it took to ejaculate. According to the literature, self-reported IELT is unscientific and therefore rejected as a method for collecting IELT data. To overcome the subjective nature of self-report data, Dismore, et al. (2006) reported a Sexual Assessment Monitor, which records ELT and does not rely on self-report data. The device fits over the penis and provides vibratory stimulation to the frenulum and at the same time accurately records times between erection and ejaculation. The results of their study indicate that the device is well tolerated and an accurate way of assessing ELT as it can be used in the clinic or at the participants' home. However, the study had to use visual sexual stimulation (a video) which would be haram for many of the participants in this research. In the pre-research trial, a dual-action masturbator was introduced as a means of providing sexual stimulation without the need for masturbation. It was rejected by patients partly because of the shape and size of the device (although it looked like an artificial vagina it had sea shell decoration on the outer cover) and party because of the importance of sexual thoughts being related to the man's partner only (refer to Ruqaiyyah Waris Maqsood [2006] on page 169).

In previous clinical experience of treating men with PE, patients reported anxiety about using a stopwatch during intercourse; indeed there was anxiety about using a stopwatch to establish ejaculatory latency time during masturbation, because it would be something to distract the man from ejaculating. Although distraction is a recognised intervention to delay ejaculation, it does not allow any re-learning by the individual, and so is of doubtful long-term benefit in helping him understand the cues that his body is giving him.

Analysis of the biomedical sub-theme of time

Using Jannini's criteria for stratifying the severity of PE of the 23 men analysed in the research, 8 had severe PE (ELT less than 15 seconds); 11 had moderate PE (ELT < 60 seconds); 3 had mild PE (ELT < 120 seconds) and 1 participant's ELT was outside the stratification level at >120 seconds but still believed himself to have premature ejaculation (refer to table 5.2). Not all participants were able to accurately estimate their own ejaculatory latencies, but were not distressed by this. What participants were universally clear about was that they *thought* they ejaculated too soon, and either they, or their partners, or both, were bothered by this.

Table 5.2 Self reported Ejaculatory Latency Time (ELT) n= 23

Descriptor	**Number**	**Respondents**
Before Penetration	1	Participant L
On penetration	7	Participant F, Participant M, Participant O, Participant R, Participant X, Participant Z, Participant A1
Less than 30 seconds	5	Participant A, Participant B, Participant P, Participant S, Participant A2
30-60 seconds	6	Participant C, Participant I, Participant J, Participant Q, Participant W, Participant Y
60-120 seconds	3	Participant D, Participant E, Participant V
120-180 seconds	1	Participant H

In medical trials, use of a chronometer is an established requirement, but what is unclear is any artefact that use of a stopwatch brings to any sexual encounter. For example, participant J said '*that the use of the stopwatch initially increased tension in his sexual relationship*'. Furthermore, even though participants were asked to record each sexual encounter, only a few actually attended clinic with a written list of their ELTs, and most claimed that they remembered the stopwatch times, which calls into question the accuracy of stopwatch-assessed ELT. Most men who had successful treatment were able to qualitatively claim an improved delay in their ejaculation times, which

they were either satisfied or extremely satisfied with. What this indicates is that self-reported ELT is valid to the individual, and that stratifying men according to ELT does not reflect the subjective experience of PE. What merit, therefore, does stratification serve? Is the assumption that those with the most severe PE would be those with lifelong PE and with the shortest ELTs?

Correlating stopwatch-assessed ELT with self-report ELT shows a marked difference between the timings (refer to table 5.3) of participants.

Table 5.3 Correlation between self-reported ELT and stopwatch-assessed ELT n=24

Participant	**Differential**	**Self-report IELT (seconds)**	**Stopwatch-assessed IELT (seconds)**
L	Acquired	Before penetration	45
F	Acquired	On penetration	25
M	Acquired	On penetration	120
O	Lifelong	On penetration	150
R	Acquired	On penetration	12
X	Lifelong	On penetration	17
Z	Acquired	On penetration	11
A1	Lifelong	On penetration	45
A	Acquired	<30	24
B	Acquired	<30	95
P	Acquired	<30	15
T	Lifelong	<30	60
A2	Acquired	<30	90
C	Lifelong	30-60	65
I	Acquired	30-60	131
J	Acquired	30-60	33
Q	Acquired	30-60	120
U	Acquired	30-60	29
W	Acquired	30-60	120
Y	Acquired	30-60	29
D	Acquired	60-120	140
V	Lifelong	60-120	28
H	Acquired	120-180	240

As indicated earlier, the differential characteristic of lifelong or acquired PE *may* be pertinent in the analysis, since the findings from the randomised trial

demonstrated this. For clarity and consistency, the data has been divided into those with lifelong PE (table 5.4) and those with acquired PE (table 5.5), as they relate to ejaculatory latency times. Very few men appear to be able to accurately assess when they ejaculate, but this may say more about the discomfort of the confession of sexual problems in the clinic, rather than an inability to know when they normally ejaculate. The gender of the clinician may also have had an effect on the narratives used to describe PE. This was exemplified by Participant R. Following the consultation with my female colleague, he hid in the toilets until she saw the next patient; then asked if I could see him. He claimed to be '*so embarrassed in discussing his condition in front of a female that 50% of the history was wrong*' – he just '*made up answers*', hoping that he answered them 'correctly'. Indeed, he reported that he was so embarrassed about discussing his sex problem that it took him 3 years to get the courage to speak to his GP.

Table 5.4 Correlation between self-reported ELT and stopwatch-assessed ELT n=6 Lifelong PE

Participant	**Differential**	**Self-report IELT (seconds)**	**Stopwatch-assessed IELT (seconds)**
O	Lifelong	On penetration	150
X	Lifelong	On penetration	17
A1	Lifelong	On penetration	45
T	Lifelong	<30	60
C	Lifelong	30-60	65
V	Lifelong	60-120	28

Table 5.5 Correlation between self-reported ELT and stopwatch-assessed ELT n=17 Acquired PE

Participant	**Differential**	**Self-report IELT (seconds)**	**Stopwatch-assessed IELT (seconds)**
L	Acquired	Before penetration	45
F	Acquired	On penetration	25
M	Acquired	On penetration	120
R	Acquired	On penetration	12
Z	Acquired	On penetration	11
A	Acquired	<30	24
B	Acquired	<30	95
P	Acquired	<30	15
A2	Acquired	<30	90
I	Acquired	30-60	131
J	Acquired	30-60	33
Q	Acquired	30-60	120
U	Acquired	30-60	29
W	Acquired	30-60	120
Y	Acquired	30-60	29
D	Acquired	60-120	140
H	Acquired	120-180	240

What this data indicates is that participants were unable to accurately estimate their ejaculatory latency times (refer to participants O, A1 and V with lifelong PE, and participants L, M. I and Q for those with acquired PE, for examples), but this may be because their estimation of ejaculatory was more akin to the level of anxiety that they felt about PE.

The next question to be asked was about how long they wanted to last, or how long they thought they should last before ejaculation (after penetration). The principle reason for identifying this was to see whether men knew what normal ejaculatory delay range was and on what basis they thought this (which forms part of the philosophical discussion of governmentality addressed in chapter seven). The responses have been tabulated (refer to table 5.6) according to common responses.

Table 5.6 How long should you last? n= 23

Descriptor	Number	Respondents
Until she is satisfied	2	Participant M, Participant P
<3 minutes	2	Participant S, Participant V
3-5 minutes	4	Participant B, Participant H, Participant J, Participant W
6-10 minutes	7	Participant C, Participant I, Participant L, Participant R, Participant Z, Participant A2, Participant A1
11-20 minutes	6	Participant A, Participant E, Participant F, Participant O, Participant Q, Participant X
>21 minutes	2	Participant D, Participant Y

The median response was 6-10 minutes (n=7) although most participants guessed at this figure and hoped that the response would be validated by me. There were no differences in the discourses related to normal delay between lifelong and acquired premature ejaculators (refer to tables 5.7, 5.8. and 5.9).

Table 5.7 Differential, Self-reported ELT, stopwatch ELT, how long should you last? n=24

Participant	Differential	Self-report lELT (seconds)	Stopwatch-assessed lELT (seconds)	Expected normal
V	Lifelong	60-120	28	Less than 3 minutes
B	Acquired	<30	95	3-5 minutes
H	Acquired	120-180	240	3-5 minutes
J	Acquired	30-60	33	3-5 minutes
W	Acquired	30-60	120	3-5 minutes
C	Lifelong	30-60	65	6-10 minutes
I	Acquired	30-60	131	6-10 minutes
L	Acquired	Before penetration	45	6-10 minutes
R	Acquired	On penetration	12	6-10 minutes
T	Lifelong	<30	60	6-10 minutes
Z	Acquired	On penetration	11	6-10 minutes
A1	Lifelong	On penetration	45	6-10 minutes
A2	Acquired	<30	90	6-10 minutes
A	Acquired	<30	24	11-20 minutes
F	Acquired	On penetration	25	11-20 minutes
O	Lifelong	On penetration	150	11-20 minutes
Q	Acquired	30-60	120	11-20 minutes
U	Acquired	30-60	29	11-20 minutes
X	Lifelong	On penetration	17	11-20 minutes
Y	Acquired	30-60	29	> 21 minutes
D	Acquired	60-120	140	> 21 minutes
M	Acquired	On penetration	120	Until she’s satisfied
P	Acquired	<30	15	Until she’s satisfied

Table 5.8 Differential, Self-reported IELT, stopwatch IELT, what is normal (Lifelong PE)? n=6

Participant	Differential	Self-report IELT (seconds)	Stopwatch-assessed IELT (seconds)	Expected normal
V	Lifelong	60-120	28	Less than 3 minutes
C	Lifelong	30-60	65	6-10 minutes
T	Lifelong	<30	60	6-10 minutes
A1	Lifelong	On penetration	45	6-10 minutes
O	Lifelong	On penetration	150	11-20 minutes
X	Lifelong	On penetration	17	11-20 minutes

Table 5.9 Differential, Self-reported IELT, stopwatch IELT, what is normal (Acquired PE)? n=17

Participant	Differential	Self-report IELT (seconds)	Stopwatch-assessed IELT (seconds)	Expected normal
B	Acquired	<30	95	3-5 minutes
H	Acquired	120-180	240	3-5 minutes
J	Acquired	30-60	33	3-5 minutes
W	Acquired	30-60	120	3-5 minutes
I	Acquired	30-60	131	6-10 minutes
L	Acquired	Before penetration	45	6-10 minutes
R	Acquired	On penetration	12	6-10 minutes
Z	Acquired	On penetration	11	6-10 minutes
A2	Acquired	<30	90	6-10 minutes
A	Acquired	<30	24	11-20 minutes
F	Acquired	On penetration	25	11-20 minutes
Q	Acquired	30-60	120	11-20 minutes
U	Acquired	30-60	29	11-20 minutes
D	Acquired	60-120	140	> 21 minutes
Y	Acquired	30-60	29	> 21 minutes
M	Acquired	On penetration	120	Until she's satisfied
P	Acquired	<30	15	Until she's satisfied

The range in expected normal was between < 3 minutes and >21 minutes. It was unclear where these expectations of normal were obtained, and men were vague and embarrassed when asked for reasons why they chose the duration that they did. Almost universally, Bangladeshi men wanted to be told what the normal range was.

Only 2 participants (M and P) wanted to last until their partners were satisfied but neither had asked their partners how long this might be. No participants indicated “until they (themselves) were satisfied” or “until we are both satisfied”. This is noteworthy since sexual activity is often about mutual enjoyment, but this was not demonstrated in the responses to this question. The 8 participants who wanted to last more than 11 minutes had expectations that, according to the published range of normal ejaculatory latency, is beyond most men, but the published literature is only based on those men willing to speculate on sexual activity/or disclose their own estimated latency times (which may be exaggerated). What this finding illustrates is the preoccupation with reducing sexual activity to a defined time range rather than a mutually enjoyable experience defined by the individuals engaged in it. Many men were concerned with fertility and the need to reproduce (usually a boy) relatively soon after marriage, but although this was cited as a concern, there was no correlation between severity of PE, duration of PE, and the number of children produced. This is discussed further in the cultural theme.

Developing this link between time and experience, a more detailed analysis of participants M and P was undertaken (both of whom indicated they wanted to last until their partners were satisfied), which shows some interesting dichotomies and contradictions between what they said they wanted to one question and what they actually said to other questions (refer to table 5.10).

Table 5.10 Comparison of responses (Participants M and P). * - claimed history

Participant	**M**	**P**
Marriage type	Arranged	Love
Number of sexual partners	1	More than 20
Pre-marital sexual activity?	No	No
Differential feature	Acquired	Acquired*
PE with all partners?	Not applicable	Yes
Duration of foreplay?	5-10 minutes	< 5 minutes
Treatment tried	Behavioural therapy	None
Motivator for seeking treatment	On failure of therapy	"sought treatment immediately on discovery of the problem"
Feelings about PE	Devastated	None

Participant M was sexually naïve (defined by number of sexual partners and absence of masturbation) and sought treatment on failure of behavioural therapy, and hence could be considered to meet the criteria for diagnosis of acquired PE. Participant P however was sexually experienced (defined by multiple sexual partners and pre-marital masturbation) and claims to have sought treatment on discovery of the problem, but this would seem a contradictory statement. This man had lifelong PE rather than acquired PE, but he claims that he had not been suffering from PE for long. What this statement indicates is that he has not been *bothered* with PE for long, and therefore it is the degree of bother in the sexual relationship that is the motivator for treatment. The expectation would be that participant P would have a greater degree of anxiety in relation to his PE because of the multiple sexual experiences that he had, indicating a chronic (lifelong) rather than an acquired problem. This may represent a separation between mind and body, or may represent a separation out of social roles and norms. Participant M had fathered 5 children whereas participant P had fathered 3 children, and conceivably that now that social expectations had been met (production of children), his partner may be trying to rid herself of a dysfunctional man (a finding already referred to by the Imam and reported in the extract from the field notes.

The final part of the time-related theme was that of the duration of foreplay (refer to table 5.11), although narratives related to this are also discussed in the cultural theme, which further illustrates the interrelationship of physiology, cognition and culture in sexual activity.

Table 5.11 How long does foreplay last? (This overlaps with cultural discourse but is related to lifelong or acquired PE) n= 23

Descriptor	**Number**	**Respondents**
PE during foreplay	4	Participant E, Participant L, Participant O, Participant R
< 5minutes	5	Participant H, Participant J, Participant P, Participant Q, Participant V
5-10 minutes	7	Participant D, Participant F, Participant M, Participant W, Participant X, Participant Y, Participant A1
11-20 minutes	5	Participant A, Participant C, Participant I, Participant S, Participant Z
>20 minutes	2	Participant B, Participant A2

The median time for foreplay was 5-10 minutes, although 4 participants were unable to engage in foreplay due to PE. For several participants, they were unaware of the concept or need for foreplay (this links with the cultural theme and sub-theme of sex education provision) and for 2 participants they did not see any need at all for foreplay. The data here would have been much richer had partners attended the appointments, but this assumes that discussions of foreplay would be permissible with a third party (which is commonly not the case).

The dissatisfaction with sexual activity that the participants' report their wives complained of may be related to the type of sexual activity engaged with. Data from Body (2004a, 2004b, 2006) suggests that women who have penile-vaginal intercourse report more satisfaction with their relationships (both physical and psychologically) when compared to other forms of sexual activity. The extent to which these findings relate to Bangladeshi women is debatable since the Brody data is predominantly drawn from European (non-

Muslim) women who may be more in tune with expressing their sexual needs, but it does indicate a potential course of investigation into Bangladeshi women's views of sexual activity, particularly if their partner has PE. Costa and Brody (2007) suggest that more frequent penile-vaginal intercourse results in more demands for penile-vaginal intercourse, and therefore indices of relationship satisfaction are improved with regular penile-vaginal intercourse (as opposed to other forms of sexual activity). However, from the few women who attended clinic, their demands were not for increased penile-vaginal intercourse per se, but for more intimacy generally. What is clear is the need for further study into Bangladeshi women's insights into sexual activity and meanings.

Analysis of the biomedical sub-theme: treatment

Treatment of PE prior to participation in the trial was variable (refer to table 5.12) and indicates a potential reluctance by clinicians to engage in discussions with men about sexual activity. There is a common finding in the clinical management of erectile dysfunction that clinicians are reluctant to discuss the subject with patients due to lack of knowledge of the condition or of subsequent treatment options (refer to Steggall, 2007) and it is a logical conclusion that discussions about PE are similarly limited.

Table 5.12 What treatment(s) have you tried previously? n= 25 Treatment rated as unsuccessful/delay not sustained (some participants had tried more than one therapy)

Descriptor	Number	Respondents
Nothing	11	Participant D, Participant C, Participant H, Participant F, Participant J, Participant M, Participant O, Participant Q, Participant V, Participant A2, Participant A1
PDE5I	6	Participant A, Participant E, Participant I, Participant L, Participant P, Participant Z
Traditional Behavioural therapies	2	Participant L, Participant X
Herbal remedy	2	Participant S, Participant Y
Cream/spray	2	Participant B, Participant R
SSRI	1	Participant V

11 participants were treatment naïve and a further 6 had been inappropriately diagnosed with ED and treated by trying a phosphodiesterase type 5 inhibitor, usually Sildenafil Citrate (Viagra). For some men, for example Participant F and Participant W, their motivation to seek treatment was a change in PERT from a few minutes to a few hours, which is a normal consequence of ageing in men, but they were 'fed up waiting' with waiting for the next erection, and therefore the importance of delaying the first ejaculation became a priority for them. Participant F for example had sexual intercourse 2-3 times per week but now only once per week because recovery time between erections is 3-4 hours. Previously he was able to have two sexual encounters per night; the second encounter would be more satisfying to his partner. Now that PERT was longer, his wife was more critical of him and less inclined to engage in sexual activity. Participant W found that his second erection lasted 30 minutes, but took too long to attain; he went on to indicate he got 'fed up waiting for the erection' second time around. The discourses around PERT will be examined further in chapter 7 as they further represent a biomedical theme, and one which is absent from the literature concerning the motivation for help-seeking behaviours.

Although only 2 participants mentioned this PERT discourse, the contention is that the main motivator for seeking treatment was due to changes in PERT. The evidence for this assumption has been drawn from the age of participants and the number of sexual partners or duration of the relationship. Very few young men were enrolled in the research; a large number of participants had been married for several years before seeking treatment, leading to the contention that one of the motivating factors was this loss of a second erection within a short space of time. The discourses are around PERT and will be examined later as they represent a major aspect of the biomedical theme.

Time and sexual experience form part of the two main diagnostic criteria for PE. Another key element of the biomedical theme, is that of definition.

Analysis of the biomedical sub-theme: definition

Three elements collectively contribute to the accepted definitions of PE. These are ejaculation before the person or his partner wishes it; interpersonal distress; and not as a result of a withdrawal of a substance (e.g. an opiate). Reviewing this definition, 3 groups of responses contribute to an overall definition of PE: the differential feature of PE (refer to table 5.13); the duration of the relationship (refer to table 5.14); and whether PE occurred with all previous partners (refer to table 5.15).

Table 5.13 How long have you had PE for (lifelong- primary or acquired- secondary)? n= 23

Descriptor	Number	Respondents
Lifelong	6	Participant C, Participant E, Participant O, Participant V, Participant X, Participant A1
Acquired	17	Participant A, Participant B, Participant D, Participant H, Participant F, Participant I, Participant J, Participant L, Participant M, , Participant P, Participant R, Participant Q, Participant S, Participant W, Participant Y, Participant Z, Participant A2

Table 5.14 How long have you been married/with current partner? n= 22

Range	Number	Respondents
< 1 year	1	Participant C
1-5 years	5	Participant A, Participant F, Participant J, Participant O, Participant W
6-10 years	6	Participant E, Participant I, Participant P, Participant R, Participant S, Participant Z
11-20 years	7	Participant B, Participant D, Participant L, Participant Q, Participant V, Participant X, Participant A1
>20 years	3	Participant M, Participant Y, Participant A2

Table 5.15 Did you have PE with all previous partners? n= 23

Descriptor	Number	Respondents
Yes	6	Participant O, Participant P, Participant R, Participant V, Participant A2, Participant A1
No	5	Participant B, Participant I, Participant J, Participant L, Participant X
N/a	12	Participant A, Participant D, Participant C, Participant E, Participant H, Participant F, Participant M, Participant Q, Participant S, Participant W, Participant Y, Participant Z

Men were asked if they had nocturnal emissions (wet dreams) to identify whether there was any difference between lifelong and acquired groups, since one of the assumptions about men with lifelong PE is that they have very short plateau phases before ejaculation (Waldinger, 2004). The results indicate that there is no difference between groups in terms of nocturnal emissions (refer to tables 5.16, 5.17, 5.18 and 5.19), that is, men with lifelong PE seem to have the same expectations of ejaculatory delay as men with acquired PE.

Table 5.16 Differential, Self-reported IELT, stopwatch IELT, what is normal and nocturnal emissions stratified according to self-report ELT. n=24

Participant	Differential	Self-report IELT (seconds)	Stopwatch-assessed IELT (seconds)	Expected normal	Nocturnal emission?
L	Acquired	Before penetration	45	6-10 minutes	Sometimes
F	Acquired	On penetration	25	11-20 minutes	No
M	Acquired	On penetration	120	Until she's satisfied	Sometimes
O	Lifelong	On penetration	150	11-20 minutes	No
R	Acquired	On penetration	12	6-10 minutes	Yes
X	Lifelong	On penetration	17	11-20 minutes	No
Z	Acquired	On penetration	11	6-10 minutes	Sometimes
A1	Lifelong	On penetration	45	6-10 minutes	Sometimes
A	Acquired	<30	24	11-20 minutes	No
B	Acquired	<30	95	3-5 minutes	Yes
P	Acquired	<30	15	Until she's satisfied	Sometimes
T	Lifelong	<30	60	6-10 minutes	No
A2	Acquired	<30	90	6-10 minutes	Sometimes
C	Lifelong	30-60	65	6-10 minutes	No
I	Acquired	30-60	131	6-10 minutes	No
J	Acquired	30-60	33	3-5 minutes	Sometimes
Q	Acquired	30-60	120	11-20 minutes	Yes
U	Acquired	30-60	29	11-20 minutes	Sometimes
W	Acquired	30-60	120	3-5 minutes	No
Y	Acquired	30-60	29	> 21 minutes	No
D	Acquired	60-120	140	> 21 minutes	Sometimes
V	Lifelong	60-120	28	< 3 minutes	Sometimes
H	Acquired	120-180	240	3-5 minutes	No

Table 5.17 Differential, Self-reported IELT, stopwatch IELT, what is normal and nocturnal emissions (yes to nocturnal emissions)? n=3

Participant	Differential	Self-report IELT (seconds)	Stopwatch -assessed IELT (seconds)	Expected normal	Nocturnal emission?
R	Acquired	On penetration	12	6-10 minutes	Yes
B	Acquired	<30	95	3-5 minutes	Yes
Q	Acquired	30-60	120	11-20 minutes	Yes

Table 5.18 Differential, Self-reported IELT, stopwatch IELT, what is normal and nocturnal emissions (sometimes have nocturnal emissions)? n= 10

Participant	Differential	Self-report IELT (seconds)	Stopwatch -assessed IELT (seconds)	Expected normal	Nocturnal emission?
D	Acquired	60-120	140	> 21 minutes	Sometimes
J	Acquired	30-60	33	3-5 minutes	Sometimes
L	Acquired	Before penetration	45	6-10 minutes	Sometimes
M	Acquired	On penetration	120	Until she's satisfied	Sometimes
P	Acquired	<30	15	Until she's satisfied	Sometimes
U	Acquired	30-60	29	11-20 minutes	Sometimes
V	Lifelong	60-120	28	Less than 3 minutes	Sometimes
Z	Acquired	On penetration	11	6-10 minutes	Sometimes
A1	Lifelong	On penetration	45	6-10 minutes	Sometimes
A2	Acquired	<30	90	6-10 minutes	Sometimes

Table 5.19 Differential, Self-reported IELT, stopwatch IELT, what is normal and nocturnal emissions (no nocturnal emissions)? n= 10

Participant	**Differential**	**Self-report IELT (seconds)**	**Stopwatch -assessed IELT (seconds)**	**Expected normal**	**Nocturnal emission?**
A	Acquired	<30	24	11-20 minutes	No
C	Lifelong	30-60	65	6-10 minutes	No
F	Acquired	On penetration	25	11-20 minutes	No
H	Acquired	120-180	240	3-5 minutes	No
I	Acquired	30-60	131	6-10 minutes	No
O	Lifelong	On penetration	150	11-20 minutes	No
T	Lifelong	<30	60	6-10 minutes	No
W	Acquired	30-60	120	3-5 minutes	No
X	Lifelong	On penetration	17	11-20 minutes	No
Y	Acquired	30-60	29	> 21 minutes	No

What the data indicates is that this question, ‘Do you have nocturnal emissions’, bears no relationship with the severity of PE or the expected duration of sexual intercourse (refer to table 5.20).

Table 5.20 Differential, Self-reported IELT, stopwatch IELT, what is normal and nocturnal emissions, listed according to duration of desired intercourse. n= 24

Participant	Differential	Expected normal	Nocturnal emission?
V	Lifelong	Less than 3 minutes	Sometimes
B	Acquired	3-5 minutes	Yes
H	Acquired	3-5 minutes	No
J	Acquired	3-5 minutes	Sometimes
W	Acquired	3-5 minutes	No
C	Lifelong	6-10 minutes	No
I	Acquired	6-10 minutes	No
L	Acquired	6-10 minutes	Sometimes
R	Acquired	6-10 minutes	Yes
T	Lifelong	6-10 minutes	No
Z	Acquired	6-10 minutes	Sometimes
A1	Lifelong	6-10 minutes	Sometimes
A2	Acquired	6-10 minutes	Sometimes
A	Acquired	11-20 minutes	No
F	Acquired	11-20 minutes	No
O	Lifelong	11-20 minutes	No
Q	Acquired	11-20 minutes	Yes
U	Acquired	11-20 minutes	Sometimes
X	Lifelong	11-20 minutes	No
Y	Acquired	> 21 minutes	No
D	Acquired	> 21 minutes	Sometimes
M	Acquired	Until she's satisfied	Sometimes
P	Acquired	Until she's satisfied	Sometimes

Analysis of the biomedical sub-theme: causation

Table 5.21 lists the common responses to questions related to possible causes of PE. Most responded 'Don't know' but several speculated on environmental condition (i.e. temperature and exposure to sunlight) as possible causes, but further stated that in the home country (Bangladesh), there was not as much pressure on them to perform sexually as there is in the UK. It was difficult to establish precisely what was meant by this statement and unfortunately language constraints prevented further questioning that would have explored this in further detail. One possible explanation may be related to the relative isolation that Bangladeshi women feel in the UK,

isolated from a wider family network and support group. For women unable to speak English, the East End of London represents a potentially dangerous environment (it is difficult to travel round the East End if English is not spoken, and there are fears of racist attacks), which may suggest the relationships experience greater strain when compared to the local indigenous population. Narratives from the few women who attended the clinical appointments with their husbands indicated that the only intimacy shown by partners was during sexual intercourse in the bedroom, which may exacerbate pressure to perform and conform to a longer ejaculatory latency time.

Table 5.21 What causes the problem? n= 27 (multiple responses)

Descriptor	**Number**	**Respondents**
Don't know	13	Participant A, Participant H, Participant F, Participant M, Participant O, Participant P, Participant R, Participant Q, Participant V, Participant W, Participant Y, Participant Z, Participant A1
Cold climate	1	Participant B
Masturbation	3	Participant C, Participant U, Participant G
Penile pain	1	Participant D
Fear/pressure to perform	3	Participant E, Participant S, Participant A2
Hot water	1	Participant I
Cannabis	1	Participant I
Prostatitis	1	Participant J
Loose nerves	1	Participant L
Weak blood	2	Participant L*, Participant X*

An interesting reformulation of the effects of PE came from Participant B, who was very keen to have a male child to ensure that his name was passed on to next generation, which was important to his construct of one of his roles in life. To illustrate the compartmentalisation between mind/body/culture that persisted in some of the men, participant B explained he went back to Bangladesh and attempted to cure himself by having sexual intercourse with someone he described as '*a good girl, not a business girl*'. He was able to delay ejaculation markedly. On return to his wife he was able to maintain a

longer ejaculatory delay, which made his relationship with his wife better. In his words “she’s not giving me hassle anymore”. He attributed his delay to a change in the weather and due to being more relaxed in his home country, where he felt more relaxed with the expectations that his family had of him. He also said that he would not ‘go’ with anyone else in the UK, but would do in Bangladesh. There may be an association between climate and PE as it relates to exposure to sunlight. Brain serotonin has been found to be involved in the regulation of many physiologic functions, such as sexual activity, energy and sleep, and the serotonin transporter regulates the intensity and spread of the serotonin signal (Praschak-Rieder, et al. 2008). There may be a serotinergic basis for PE in men from temperate climates, and this warrants further investigation and analysis.’

Participant G believed that PE was caused by learnt behaviour, believing that masturbation is forbidden by his religion, and suggesting that semen was a life-form and therefore masturbation is a waste of life. Participant U was told by a healer that ‘*watching pornographic movies and masturbating caused the problem*’*,* as was participant H. Participant L didn’t know the cause of PE but said that ‘*he saw doctor in Bangladesh who said it was a loose nerve*’. He doesn’t believe this and thinks it is related to ‘*blood seizing up in his body*’. He is sure that masturbation has made it worse.

Participant X thought that thin sperm was the cause of PE, and was very worried about weak semen and concerned with pre-ejaculate. He attributed ‘*weak semen with weak (poor quality) erections*’. He was keen to explain PE in terms of erection quality and was adamant that ‘*there was a physical cause for PE*’; masturbation as a younger man was the opinion about causation. This is an important finding as most behavioural therapies advocate some form of solitary or mutual masturbation as a treatment. Although the Imam’s who formed part of the steering group clearly informed the research team (and the participants) that masturbation as a treatment programme was permissible within Muslim culture/faith, it would seem that not all adherents of that faith were willing to believe this.

Another potential exacerbating feature of causation of PE was related to opportunity for sexual activity and tiredness. Although all participants indicated that they only shared their bed with their partner, most had young children in the same room with them. Children up to the age of 6 or 7 years commonly shared bedrooms with their parents due to the social conditions that the participants had. This may restrict spontaneity in sexual activity/opportunity, which will further add pressure to the sexual encounter, thus increasing performance anxiety and premature ejaculation. These changes in spontaneity and opportunity were exemplified by Participant G who stated that his '*wife, who breast fed, was so tired that they rarely had sex, so when they did, it was important for it to last longer*'.

Alternative narratives relate again to changes in PERT. Participant W was aware that his ELT was getting shorter whereas his PERT was getting longer. The first erection would last a minute or so, then he'd wait 10 minutes, then be able to last 30 minutes. His reason for seeking treatment was to make the first erection last longer because the time to gain the second erection was getting longer and longer.

The explanations for PE are explored in more depth in the cultural theme, but many men were keen to deploy a biomedical discourse to explain PE. For example, Participant X was convinced that PE was '*caused by venous leak*' and "*definitely had nothing to do with feelings/thoughts*". He couldn't understand why no-one was taking any notice of the venogram that he had had. He was keen for a medical diagnosis, a medical cure and a medical label; in essence, he rationalised the experience by entering into a mind-body dualism, and engaged in a body-as-machine discourse. For him, at least, this separation had the advantage of locating the resolution of the problem outside the body, by which it is the clinician that has responsibility for diagnosis, treatment and cure. Failure of treatment and failure of cure was therefore the clinician's (researcher's) fault. Whilst most of the narratives did not use such an extreme medical discourse in explaining their PE, most looked externally, outside of their own bodies, for the solution or the cure; employing sometimes subtle and sometimes unsubtle discourses to attempt to coerce me to provide

"*the best medicine*". This is a prime example of discourses related to governmentality. These discourses will be explored further in chapter seven.

What is clear from these narratives is that defining PE in terms of time alone does not meet the expectations of the men who seek treatment. Furthermore, for many of the Bangladeshi participants they wanted to be a passive recipient of my care, and divorce themselves from the problem by locating the solution outside or away from themselves and expecting me to look *into* the body to locate and fix the problem. For some men at least, they seem to be content with the medicalisation of sexual activity and would accept what Foucault would refer to as scientia sexualis.

Key points from Biomedical discourses

83% of the participants self-reported their ELT at less than 60 seconds, which can be categorised as severe PE if Jannini's classification is adopted. 69% reported acquired PE, but the most common duration of the condition was 6-10 years. This obvious discrepancy between duration of PE in years and whether it is an acquired problem is partially explained by the discourses used to explain PE (from both medical and lay perspectives) and partly due to lack of understanding of normal sexual function, specifically the age-related changes that occur resulting in changes in recovery times and the conditions needed for sexual activity, i.e. privacy and foreplay. The responses indicated that most men were possibly lifelong premature ejaculators, but as young men they were able to achieve a second erection relatively quickly. This second erection would then be sustained because the ejaculatory latency time was extended as part of the normal neurophysiology of ejaculation. The key motivator for these men to seek help was the lengthening time between erections, referred to as post ejaculatory recovery time or PERT. Participant F reported a change in PERT to 3 to 4 hours. A further confusing factor, for some men at least, was that if they had fathered children, their partners' did not attribute the same importance (or demands) for good (however defined) sex. The assumption being that social (reproductive) expectations of sexual

activity had been met and this changed the importance of sexual activity within the relationship.

One critical discussion related to timing is to establish when desire for sexual activity occurred and if this influenced time to ejaculation. It is impossible to be precise in identifying the time that desire occurred, or indeed of the factors that influenced desire, but a possible indirect indicator is that of foreplay; a man confident of ejaculatory delay may be expected to engage with foreplay for longer than a man unable to delay ejaculation. The median desired ELT was 6-10 minutes and the median duration of foreplay was 5-10 minutes. Of course, the degree of foreplay may also be related to the amount of sexual experience. However both may influence expectation of sexual activity and the subsequent estimations of normal ejaculatory latency. The median foreplay time was 5 to 10 minutes, although some men were confused by the question. For 2 patients, foreplay had to be explained. The response from participant L exemplifies this: '*when I want sex I just tell her and start*'. This is of interest because of the loss of intimacy present in some relationships is indicated by absent/limited shared social activity, which will be discussed further in chapter seven.

Although most men were treatment naïve, 24% had tried a phosphodiesterase type 5 inhibitor, but without success. The reason for use of PDE5Is may be related to terminology to describe PE. Many men reported erection failure, and only by focussed questioning was it possible to differentiate between erection failure and detumescence following ejaculation. However, some researchers have found that Sildenafil Citrate shortens PERT (Abdel-Hamid, et al. 2001), and therefore helps in a shorter recovery time between erections, whereas others suggest that PDE5Is can help men by reducing performance anxiety (Salonia, et al. 2002; Chen, et al. 2003).

For the Bangladeshi participants the most common motivators for treatment were changes in PERT (although this was not verbalised as such) and encouragement from their partners. Irrespective of motivation for treatment, all

Bangladeshi participants were keen to locate the cause of PE in terms of physicality. The next theme to be addressed is psychology.

B. Psychological discourses to explain PE

Psychological narrative exploring PE are motivators for seeking treatment; concepts of masculinity; expectations of normal sexual behaviours; and the power associated with semen. This section of the results analysis begins with motivators for seeking treatment. The narratives illustrate the dissociation between the man's feelings/needs and his interpretations of the expectations of relationships.

The main motivating factors for seeking treatment have been grouped into 8 common discourses (refer to table 5.22). The most common responses were 'sought treatment immediately' (n=8), 'Wife hassling or encouraging him' n=5, and 'He was unhappy (with his ejaculatory delay)' n=4. Failure 'of previous treatments' n= 6 were also cited as reasons for seeking behaviour, although further discussion indicted that it was unacceptability of treatment, whether medical, psychological or alternative therapy, that was the main motivator for seeking treatment. Furthermore these were coupled with pressure from a partner.

Table 5.22 What/who made you seek treatment now? n= 24

Descriptor	Number	Respondents
Wife hassling him	2	Participant F, Participant A1
Wife encouraging him	3	Participant A, Participant B, Participant V
He wanted treatment – he is unhappy	4	Participant D, Participant Y, Participant Z, Participant A2
Both keen for treatment	1	Participant C
Failure of previous treatment (psych)	2	Participant E, Participant X
Failure of prev. treat (med)	3	Participant M, Participant R, Participant W
Failure of prev. treat. Other	1	Participant L
Sought treatment immediately on discovery of problem	8	Participant H, Participant I, Participant J, Participant O, Participant P, Participant Q, Participant S, Participant U

Central to knowledge(s) of PE is identification of how men internalised having PE and whether they were able to compartmentalise their lives. Were they able to disassociate sexual roles from social roles, or did their PE affect their whole lives, and why? As an introduction to exploring the impact of PE on men questioning began about how the man saw himself with PE (refer to table 5.23) and then went on to ask whether PE affected their sexual lives only, or whether there was a more global impact on their lives (refer to table 5.24).

Table 5.23 How does PE affect how you see your self/role as a man? n= 23

Descriptor	**number**	**respondents**
Bad /devastated	5	Participant L, Participant R, Participant Q, Participant X, Participant A1
Depressed	5	Participant A, Participant E, Participant F, Participant O, Participant Z
Unhappy	8	Participant C, Participant H, Participant I, Participant M, Participant P, Participant S, Participant W, Participant A2
Angry	1	Participant X
Worried	3	Participant B, Participant J, Participant V
Not at all	1	Participant D

Perhaps unsurprisingly, most men felt some degree or bother in relation to their sexual lives, but it was difficult to ascertain whether they were bothered because their partners were giving them 'hassle' as participants put it, or whether they had an unrealistic expectation of what was normal sexual activity. Correlating the effects of PE on the self with both stopwatch-reported ELT and self-reported ELT (refer to table 5.48) indicates that only participants R, Z and P had severe PE, but how this was internalised by each participant was different. This is not a significant finding, since sexual activity has different meanings for each individual, but what is of interest is that the actual or estimated time of ejaculatory latency did not bear any relationship to the impact of PE on the man, which further illustrates the need to treat with caution the recommendation to stratify men's PE into severe, moderate or mild, because these arbitrary terms do not bear any relationship to the impact of PE on men.

Table 5.24 Correlation between impact of PE and estimated/stopwatch ELT. n= 23

Participant	Affect on self/role as a man	Stopwatch ELT (seconds)	Self-report ELT
L	Bad/devastated	45	Before penetration
R	Bad/devastated	12	On penetration
Q	Bad/devastated	120	30-60 seconds
X	Bad/devastated	17	On penetration
A1	Bad/devastated	45	On penetration
A	Depressed	24	<30 seconds
E	Depressed	-	-
F	Depressed	25	On penetration
O	Depressed	150	On penetration
Z	Depressed	11	On penetration
C	Unhappy	65	30-60 seconds
H	Unhappy	240	120-180 seconds
I	Unhappy	131	30-60 seconds
M	Unhappy	120	On penetration
P	Unhappy	15	<30 seconds
S	Unhappy	-	-
W	Unhappy	120	30-60 seconds
A2	Unhappy	90	<30 seconds
X	Angry	17	On penetration
B	Worried	95	<30 seconds
J	Worried	33	30-60 seconds
V	Worried	28	60-120 seconds
D	Not at all	140	60-120 seconds

From the data presented in table 5.24, it is evident that the experience of PE is unique for each individual. Unlike data from Bangladeshi men with Diabetes mellitus, where health inventories have been successfully used (refer to Greenhalgh, et al. 2005), the Bangladeshi participants in this research were reluctant to complete questionnaires of any description (for fear of becoming known as a premature ejaculator) and were reluctant to complete any form of standardised questionnaire. The reason for this was ostensibly the difficulty with English, but on closer questioning, it was because of the sexual content.

Turning now to how PE affected men generally (refer to table 5.25) it can be seen that the impact of PE on the relationship indicated that, for some at least, participants' relationships had deteriorated to the point where sexual activity was no longer engaged in.

Table 5.25 How does this impact on your relationship generally and sexually? n= 22

Descriptor	Number	Respondents
Devastating: no longer engaging in physical contact	3	Participant F, Participant L, Participant A1
Beginning to cause problems	6	Participant C, Participant E, Participant J, Participant V, Participant W, Participant A2
No problems	12	Participant A, Participant B, Participant D, Participant H, Participant I, Participant P, Participant O, Participant Q, Participant S, Participant X, Participant Y, Participant Z
Devastating because he can't make her happy	1	Participant M

This is of particular interest when these results are correlated with motivations for treatment (refer to table 5.26). Participants F and A1 both reported that the main motivator for seeking treatment was hassle from their wife, but both also reported that physical contact was no longer present in their relationships. Given this finding, no treatment would be likely to succeed until intimacy was restored in the relationships.

Table 5.26 Motivating factors for treatment seeking, correlated with impact on life. n= 22

Participant	Motivator	Impact on life
F	Wife hassling him	No physical contact
L	Failure of other therapy	No physical contact
A1	Wife hassling him	No physcial contact
C	Both keen for treatment	Beginning to cause trouble
E	Failure of treatment	Beginning to cause trouble
J	Sought immediate help	Beginning to cause trouble
V	Wife encouraging him	Beginning to cause trouble
W	Failure of treatment	Beginning to cause trouble
A2	He is unhappy	Beginning to cause trouble
A	Wife encouraging him	No problems
B	Wife encouraging him	No problems
D	He is unhappy	No problems
H	Sought immediate help	No problems
I	Sought immediate help	No problems
P	Sought immediate help	No problems
O	Sought immediate help	No problems
Q	Sought immediate help	No problems
S	Sought immediate help	No problems
X	Failure of treatment	No problems
Y	He is unhappy	No problems
Z	He is unhappy	No problems
M	Failure of treatment	Devastated

From the responses recorded there is a discrepancy between the man's perspective about PE and his partner's. It was difficult to gage the level of support that female partners showed to participants. For men whose partners verbalised annoyance with them, the nature of verbalisation took the form of threats such as "I will take the children back to Bangladesh. When you are better, I will come back and bring the children with me". These men were more devastated with the consequences of PE than the condition itself. Linking the self-reported effects of PE to hoped-for ejaculatory latency time did not reveal any narratives reflecting hope to delay their ELT until the man was satisfied. Interestingly, for 14 men, they were not bothered by their PE and their motivation for treatment was from a desire to please their partners (refer to table 5.27). Within this group, 5 (out of 14) men indicated that their partners were not bothered by PE and but were supportive of them seeking

treatment. This is interesting given the diagnostic criteria for PE (on or before him or his partner wishes it).

Table 5.27 Subjects perception of how his partner feels about PE (non-verbal display of annoyance) n=14

Participant	Differential	Patient perception	Partner perception	Severity
A	Acquired	No problem	Physical	Moderate
B	Acquired	No problem	Physical	Mild
D	Acquired	No problem	None	Mild
H	Acquired	No problem	Physical	Mild
I	Acquired	No problem	None	Mild
O	Lifelong	No problem	Physical	Mild
P	Acquired	No problem	None	Severe
Q	Acquired	No problem	Physical	Mild
R	Acquired	No problem	Physical	Severe
T	Lifelong	No problem	None	Moderate
X	Lifelong	No problem	Physical	Moderate
Y	Acquired	No problem	Verbal	Moderate
Z	Acquired	No problem	Physical	Severe

The next step in the analysis was to divide the responses related to the impact of PE into 3 categories; the patient's perception of his condition, how his partner treats him, and the severity category suggested in the literature. Five men used a discourse that indicated that they were completely devastated by their condition. Devastation in the context of the narratives were defined as problems in the relationship; the sexual problems were pervading their relationships, so the relationship in general was breaking down. For 2 of these men, their partners were non-verbally critical of their partners sexual performance, illustrated by Participant A '*wife just tuts*'; for the remaining 3 men, their partners were verbally annoyed with them and for 5 of them, they were, in their words '*sent in to get sorted out*'. Interestingly, however, none of the men meet the suggested severe category of PE.

Key:

Patient perception

1 - Devastated – no physical contact with partner at all now

2 - Limited - Problems confined to sex life only

3 - None - No problems

Partner perception

Verbal – verbalised annoyance

Physical – non-verbalised annoyance

None – partner not bothered and is supportive

The data was then stratified into whether the participant had lifelong or acquired PE (refer to tables 5.28 and 5.29 respectively).

Table 5.28 Subjects perception of how his partner feels about PE (non-verbal display of annoyance)

Participant	**Differential**	**Patient perception**	**Partner perception**
A1	Lifelong	Devastated	Verbal
C	Lifelong	Limited	None
V	Lifelong	Limited	Verbal
O	Lifelong	No problem	Physical
X	Lifelong	No problem	Physical

Table 5.29 Subjects perception of how his partner feels about PE (non-verbal display of annoyance) n=17

Participant	Differential	Patient perception	Partner perception
L	Acquired	Devastated	Verbal
F	Acquired	Devastated	Physical
M	Acquired	Devastated	Verbal
J	Acquired	Limited	Verbal
U	Acquired	Limited	None
W	Acquired	Limited	None
A2	Acquired	Limited	Physical
R	Acquired	No problem	Physical
Z	Acquired	No problem	Physical
A	Acquired	No problem	Physical
B	Acquired	No problem	Physical
P	Acquired	No problem	None
I	Acquired	No problem	None
Q	Acquired	No problem	Physical
Y	Acquired	No problem	Verbal
D	Acquired	No problem	None
H	Acquired	No problem	Physical

The results indicate that partner distress is one of the motivating factors prompting men to seek help. Since penetrative vaginal intercourse is merely one of several activities that can be engaged in, the nature of activity and the duration of foreplay was identified, as potential exacerbating factors in PE. Pre-research findings, and indeed findings from the ED clinic, indicated that some men used alternative forms of sexual activity to meet their partner's needs, commonly extending foreplay, or engaging in mutual masturbation and oral sex. It was expected, therefore, that men with PE would also engage in similar activity. Table 5.30 identifies whether men ejaculated during foreplay and how long foreplay would normally last. This has been correlated against partners' responses to PE.

Table 5.30 Subjects perception of how his partner feels about PE (Verbal display of annoyance) n=6

Participant	Differential	Duration of foreplay (minutes)	Sex before marriage?	Married/ relationship for (years)	Self-report IELT (seconds)
E	Lifelong	PE during foreplay	No	6-10 years	60-120
L	Acquired	PE during foreplay	Yes	11-20 years	Before penetration
J	Acquired	<5 minutes	No	1-5 years	30-60
V	Lifelong	< 5 minutes	No	11-20 years	60-120
Y	Acquired	5-10 minutes	No	> 20 years	30-60
A1	Lifelong	5-10 minutes	No	11-20 years	On penetration
M	Acquired	5-10 minutes	No	> 20 years	On penetration

For men whose partners' indicated non-verbal annoyance, for example, tutting when he ejaculated, the correlation is identified in table 5.31.

Table 5.31 Subjects perception of how his partner feels about PE (Non-verbal display of annoyance) n=15

Participant	Differential	Duration of foreplay (minutes)	Sex before marriage?	Married/ relationship for (years)	Self-report IELT (seconds)
O	Lifelong	PE during foreplay	No	1-5	On penetration
R	Acquired	PE during foreplay	No	6-10	On penetration
H	Acquired	<5	No	Data missing	120-180
Q	Acquired	<5	No	11-20	30-60
F	Acquired	5-10	No	1-5	On penetration
X	Lifelong	5-10	No	11-20	On penetration
A	Acquired	11-20	No	1-5	<30
S	Acquired	11-20	No	6-10	<30
Z	Acquired	11-20	No	6-10	On penetration
B	Acquired	>20	No	11-20	<30
A2	Acquired	>20	No	>20	<30

For those men claiming that their partners were supportive, the correlation is shown on table 5.32.

Table 5.32 Subjects perception of how his partner feels about PE (Supportive partner) n=8. * Participant T wasn't bothered because of a short PERT

Participant	Differential	Duration of foreplay	Sex before marriage?	Married/ relationship for (years)	Self-report IELT (seconds)
P	Acquired	< 5minutes	No	6-10	<30
T*	Lifelong	5-10 minutes	Yes	1-5	<30
W	Acquired	5-10 minutes	No	1-5	30-60
C	Lifelong	11-20 minutes	No	<1	30-60
D	Acquired	11-20 minutes	No	11-20	60-120
I	Acquired	11-20 minutes	Yes	6-10	30-60
U	Acquired	11-20 minutes	Not married	<1	30-60

Turning now to another common finding, low educational achievement/low social class, the cited observation from Jannini, et al. (2005) was that men with low educational achievement were more likely to report PE. In this research, most men were either not working, or working in low-paid and low status occupations. Educational attainment was school leaving level, with few attending college or university. Of those men who were educated in Bangladesh, none had gone onto higher education in any form. These were the majority of men in the research, but the precise relationship between educational attainment and PE does not appear to be a linear one. What may explain the predominance of this group in the participation of the trial is more likely linked to a greater focus on issues of depravation. What is meant here is that, for men on very low incomes, their opportunities for activities outside the home become limited. Consequently there may be greater emphasis placed on sexual activities, and the need for these to be good (however that is defined by the partner). The cauldron of living in East London (Tower Hamlets is one of the most deprived boroughs in the UK), low income, and threats to culture from the indigenous population, all serve to restrict opportunities for exposure to an outside life. Perhaps for these men, and their partners, sexual activity is more important than for others'. However, because the sample

predominantly contained a homogenous (i.e. Bangladeshi, Muslim, Low-paid) group, no comparisons were possible with other income/socio-economic groups. Cultural, social and economic variables have been shown to be predictors of access to services, patterns of service use, and prevalence of sexual health problems (Beck, et al. 2005).

Within Bangladeshi communities socioeconomic depravation and environmental problems appear to be particularly exacerbating factors. Some clinician's lack of understanding of cultural mores surrounding sexual education and sexual behaviour are reported to be key factors influencing utilisation of health services by Bangladeshi immigrants and their families (Beck, et al. 2005). It is well recognised that lower socioeconomic status groups are less able to access sexual health services, and therefore cultural and sub-cultural factors, underpinned by economic and social inequalities, can have a marked impact on sexual behaviours and access to treatment (Beck, et al. 2005).

The motivation for help-seeking treatment may also be to save their marriages, indeed some commentators suggest that claiming that the husband has PE allows grounds for divorce. This is certainty true in Muslim cultures, but if the motivation was to confirm grounds for divorce, then many of the patients would have become divorced during the treatment programme. The reality was not the case; indeed the only couple to divorce was a white UK patient, and this was after 30 years of marriage (and lifelong PE).

Psychological causes of PE have been suggested by Jannini et al. (2007) to be Guilt (belief that sexual activity is sinful, for example pre-marital or extramarital sex); Fear (of pregnancy, sexually transmitted infections, or inappropriate sexual activity, again either premarital or with someone of the same gender); and Anxiety (generally or related to sexual performance). In examining the narratives from Bangladeshi men, are all three of Jannini's aetiological causes are found. Guilt that masturbation is sinful; Fear that someone in the community will know that he is a premature ejaculator, and Anxiety that he will not be able to father boys, as a result of masturbation and

the relationship between weak semen and the production of girls.

For the Bangladeshi men, the common theme in the narratives was of fear and anxiety, and to a lesser extent, of guilt about lustful thought or masturbation as a young man. For example, Participant M was very anxious that participation in the research remained completely confidential; in his words PE was "*very shameful; if anyone were to find out, it would bring great shame on my family*".

Jannini, et al. (2007: 143) state that 'distortions of belief and false convictions about sexuality are established in childhood as a consequence of adverse influences on sexual behaviour.' Certainly nearly all of the men who identified themselves as Muslim reported no sex education at School and none from home. Indeed, Participant I when asked about the apparent lack of sex education said that:

> '*We are Muslims, so we learn by trial and error. Sex education is taboo and would not be discussed openly in the home. I would get slapped for talking about it [sex] at home; no sexual content on TV – channel would be changed to protect from lustful thoughts; no sex until marriage.*'

What can be demonstrated from these narratives is the separation from body and mind, and an assumption that individuals will somehow know what normal sexual activity is, and how to overcome any sexual problem that may manifest. A fulfilling sexual relationship is, according to McCabe (1997), an integral part of a man's emotional and psychological well-being. Lack of control over ejaculation can therefore deprive the couple of intimacy, which is indicated by the narratives used to express the effects of PE. What is interesting is the absence of the contemporary female voice in explaining the effects and impact of PE.

Results from the pan-European online survey indicate that female partners of men with PE are significantly affected by the syndrome (Barnes, 2007) and the results of this research bear out this finding, albeit identified by the narratives that men use when asked how they think their wives/partners feel.

It is unsurprising that both partners feel distressed by the condition; particularly when children are the desired outcome of the union. The voice of the actual women affected by the syndrome is missing. Although women were invited along with the men to participate in the initial and indeed subsequent visits, very few women attended. For those who did attend, they were 'British' or 'Westernised' Bangladeshi women, who had a strong sense of either supporting their husband, or an awareness that this condition involved them, in terms of their enjoyment of sexual activity, and in terms of them having to be part of the behavioural intervention. However, a greater number of narratives indicated that the problem was the man's alone and therefore the solution was the man's alone. To illustrate:

> '*Bengali Muslim women will never discuss sexual activity with a third party, and certainly not with a male clinician. Only men can do this, and only with other men. Sex can only be discussed in the confines of marriage and never to a third party. It is a private affair; if there is a problem, it is for the man to sort out on his own*' Participant S

This narrative explanation was reinforced by one British Bangladeshi woman. She explained that sex, or discussions of sex, can only be undertaken between a man and his wife, and can only be conducted in their bedroom. She went on to say that most women would not be able to discuss sex in front of another man, even though they were a clinician.

It would appear from the reported narratives that, for those men in whom the medication delayed IELT, their partners were happier with their sex lives. However, use of pharmacological intervention does not address the emotional issues related to PE. What did come out of the consultation with the one of the couples who attended together, was that the only physical intimacy that could be shown was during sexual activity. This particular woman simply wanted her husband to show her affection; because this was only done through intercourse, and because intercourse lasted so briefly, she was able to articulate why she was unhappy. When asked if she thought this would be common amongst others from her cultural group, she went on to say that very

little intimacy is shown in her culture. This narrative view was confirmed by a clinical colleague's interview with Bangladeshi women.

Whilst Barnes' (2007) assertion that couple therapy may be helpful in enhancing sexual and relationship satisfaction, this is solely dependent on the female partner attending clinic and being willing to engage in discussions about their sexual lives, outside the traditional boundaries of where these discourses can legitimately occur. There would appear to be psychological differences between cultural groups, i.e. between the participants of Barnes' trial and those of the participants in this research, which prevent these discussions. Until research on Bangladeshi women's views of PE is explored there can only be speculation on suitable strategies to foster engagement.

The final section related to psychological discourses is associated with sources of information, or more accurately acceptable sources of information about PE (refer to table 5.33).

Table 5.33 Have you sought information about PE from any other source (friends, family, Internet, etc.) - Sources of lay knowledge. n= 24

Descriptor	**Number**	**Respondents**
No-one	4	Participant M, Participant P, Participant W, Participant Y
Sex videos/porn	1	Participant A
Asked friends	5	Participant B, Participant H*, Participant L, Participant O, Participant A2
GP only	13	Participant D, Participant E, Participant F, Participant I*, Participant J, Participant O, Participant Q, Participant R, Participant S*, Participant V, Participant X, Participant Z, Participant A1
Internet	1	Participant C

*Participant I "*only discussed with wife; difficult to discuss. Feels she is bothered – no overt display but she sometimes tuts when he ejaculates early*". Participant S – "*no advice sought, but his wife asked their GP. GP recommended going to a clinic in India (GP was Indian)*". Participant H was

told by healer that '*watching pornographic movies and masturbating caused the problem*'.

91% of participants reported religious observance. The significance of religious observance comes from Participant F who stated that 'I pray daily but I can't pray if I have ejaculated; I must have a full wash – bath and complete change of clothes, and be completely fresh before praying'. 'Any urethral discharge that means I cannot pray'.

Religious discourses were also used to explain permissible activity in respect of treatment: Participant V – '*You can only do what is said you can do in the Koran – if it isn't in the Koran then you can't do it*.' Participant Y believed that masturbation was a sin in Muslim culture, but didn't know why. Other discourses also centred on religion and inability to engage in pre-marital sexual activity. Participant I said '*We are Muslims, so we learn by trial and error. Sex education is taboo and would not be discussed openly in the home. There are cultural issues here as well; would get slapped for talking about it at home; no sexual content on TV, the channel would be changed to protect from lustful thoughts; no sex until marriage.*'

Key points from psychological discourses

The main motivations for seeking treatment were grouped together, but were the most difficult to clearly deconstruct. The most common response was that "treatment was sought immediately", but participants O and P reported that they had PE with other partners; participant O reported lifelong PE; and all who reported that they sought immediate help had been married for more than a year. What this illustrates is that the narratives that men use to describe PE are often contradictory, which leads to the contention that they may be giving the responses that they may think the clinician/researcher wants to hear, rather than giving an accurate picture of their sexual history. This brings into question the accuracy of history taking. For example, how

good is the patient as his own historian, or how good is the clinician in asking the right questions to elicit a focussed and pertinent history? This is particularly difficult where participant's first language was not English, and where concepts do not easily translate across languages (assuming of course that participants agreed to have health advocates involved).

All but one participant was bothered with PE, with 81% reporting levels of stress ranging between devastated to very unhappy. This leads to speculation that an additional level of pressure is apparent in men with PE to meet norms of ejaculatory delay. For participant I his wife 'tuts' when he ejaculates early, resulting in additional pressure for him to perform so that she doesn't do this. Linking these responses with how men thought their partners felt about PE shows that 71% of partners verbalised annoyance or were non-verbally annoyed with their partners. For many men, the motivation for treatment was from their partners, who had "sent" them to get help. For 2 participants, they were told that "once they were cured their wives would come back to the UK and bring the children with them". Treatment for PE largely depends on mutual sexual activity or solitary masturbation, and for these men they reported that masturbation was haram. Given these pressures to perform, it would be difficult to offer any curative intervention (aside from general relationship counselling, which can only effectively occur if both partners engage with the counselling).

One of the most interesting discourses centred on what normal ejaculatory latency was. Out of 23 qualitative responses, only 2 wanted to delay "until she was satisfied" (refer to figure 5.10). Most constructed normal sexual activity by describing a timeframe, but no indication of time was provided, and no ranges offered to guide the responses during the interviews. 2 men wanted very long ejaculation times, i.e. >21 minutes. For many men, PE caused marked problems within the relationships and within the man himself, which is consistent with the diagnostic criteria from the American Psychological Association (DSM-IV; 1999).

One of the most important findings was that there was little or no intimacy in the relationships outside of the bedroom, leading to the speculation that sexual intercourse had more to do with intimacy rather than sexual activity itself, and that women were often the driving force behind the referrals, evidenced by the “wife giving me hassle” comment.

The final narratives relate to cultural issues.

C. Culture

Themes related to culture were the most difficult to locate, partly because culture is not a static position and partly because psychology and culture are linked together. Most of the participants in the research were sexually naïve and had not engaged in pre-marital sexual intercourse; most had a degree of guilt related to masturbation, and some believed that masturbation caused PE. Many participants reported pressure to have children, illustrated by the narrative from Participant C, who was very anxious that his wife fell pregnant at the soonest opportunity, which was in preference to a mutually enjoyable sexual life. These findings indicate home country expectations.

Bangladesh is a patriarchal society in which male domination and women’s subordination are almost universal phenomena (Aziz and Maloney, 1985; Khan, et al. 2002). Gender ideals are major forces shaping people’s social and sexual lives, and gender-appropriate social and sexual roles demonstrate both men’s and women’s family responsibilities within the context of power relations in the family and society (Khan, et al. 2002). As with other South Asian countries, Bangladeshi men are conventionally considered the breadwinners and the guardians of the family (Aziz and Maloney, 1985).

Marriage is traditionally seen as the only accepted bond for men and women (Jones, 1994). Marriage is endorsed as a social, sexual and economic relationship between male and female genders and marriage is considered a way of fulfilling the obligation to family and society as well as the ultimate romantic ideal (Hartmann and Boyce, 1988).

In Islam, marriage offers the only legitimate way of achieving sexual satisfaction and marriage is considered a moral and religious shield against promiscuity; a means of legitimising sexual relations between husband and wife for reproduction, keeping a family life and maintaining the heredity of the family line (Esposito, 1998).

Discourses that have a cultural or religious theme included the number of sexual partners; engagement in premarital sex; sex education; knowledge of sexual positions and willingness to experiment; causation of PE; sources of information; religiosity; and masturbatory practices. Religiosity is associated with broader attitudes of sexual restraint that is particularly suspicious of activities which involve sexual pleasure but have no reproductive potential (Cowden and Bradshaw, 2007). The majority of participants had arranged marriages. For some, they had not met their partners before their wedding days, and confessed to being scared when it came to consummating their relationships.

Few participants had engaged in premarital sexual activity or masturbation. Only two participants (I and L) had engaged in sexual activity with their wives before their wedding night. The remaining participants indicated that both they and their partners were extremely anxious in respect of sexual activity, and a few were unable to consummate their relationship for several months due to performance anxiety.

The majority of participants had only had sexual activity with their wives. Opportunities for premarital sexual activity were limited and participants indicated that contact with females was limited after puberty.

Knowledge of sexual activity, or at least knowledge that wasn't based on hearsay or pornographic media, was limited. Few, if any, had discussions of sexual activity from parents, and only those educated in the UK received any form of sex education. Participants reported that if any sexual content was

seen on television, the channel would be changed over. In the words of participant I:

"*if you tried to have a discussion about sex, you'd get slapped*".

This absence of information about sexual activity seems dichotomous with the aims of Islam, which is a religion where the family unit is a desirable state. Drawing on extracts from the Koran, this can be explained by the finding that premarital sexual activity is prohibited; that privacy between unrelated people of the opposite sex after puberty is haram in order to prevent temptation. The assumption is that men and women would naturally find each other attractive and therefore be physically stirred. This also accounts for the strict dress code observed within Muslim adherents. A quote from Abu Dawud says that if a man happens to have a sexual urge for someone other than his wife he should 'go straight to his wife and have intercourse with her, for that would take care of what he had felt' (Ruqaiyyah Waris Maqsood, 2006: 206).

Based on this translation of the Koran, it is unsurprising that the knowledge of sexual functioning was poor (refer to table 5.34). As Hennick, et al. (2005) indicate, open discussion of sexuality is discouraged, subsequently little is known of sexual attitudes and behaviour. Many individuals are poorly informed about sexual issues, reproductive biology and health.

Table 5.34 How did you learn about sex? n= 23

Descriptor	**Number**	**Respondents**
On own / trial and error	8	Participant B, Participant C, Participant I*, Participant J, Participant L, Participant M, Participant X, Participant Y
Discussions with friends	8	Participant A, Participant E, Participant O, Participant P, Participant S, Participant V, Participant W, Participant A2
Porn	4	Participant D, Participant F, Participant Q, Participant A1
After marriage	2	Participant H, Participant R
Formal sex education	1	Participant Z

Religious discourse was also used to explain permissible activity in respect of treatment: Participant V stated '*You can only do what is said you can do in the Koran – if it isn't in the Koran then you can't do it.*' Participant Y believed that masturbation was a sin in Muslim culture, but didn't know why. Other discourses also centred on religion and inability to engage in pre-marital sexual activity. As indicated previously Participant I said:

> '*We are Muslims, so we learn by trial and error. Sex education is taboo and would not be discussed openly in the home. There are cultural issues here as well; would get slapped for talking about it at home; no sexual content on TV, the channel would be changed to protect from lustful thoughts; no sex until marriage*.'

Sexual activity also creates further difficulties for some Muslim men. Participant F stated that '*he must pray 5 times per day*', but he could not do this if he ejaculates. He had to '*have a full wash*' (bath and complete change of clothes) and '*be completely fresh before commencing prayer*'. This finding would have implications for those men who wanted to engage in behavioural therapy in that they would need to wash several times per day as they practised the stop/start masturbation technique.

Not all men were orthodox in adherence to their faith. 45% of participants did not adhere to regular prayers or indeed fasting during Ramadan. Some men engaged in masturbation, but mostly this was pre-marital activity. Cited reasons for absence of masturbation after marriage included 'it's morally wrong' (Participants D, F, R and Y) to 'it's unnecessary because I am married' (Participants, E, M, O, P, Q, S, W, X and A1).

In trying to establish where cultural norms were learnt in relation to sexual activity, participants were asked when sex education had occurred, if at all, and to identify some of the reasons why they were sexually naïve when first married. Responses have been collated in table 5.35, and stratified according to differential features in tables 5.36 and 5.37.

Table 5.35 Differential/self-report IELT, sex education, reaction of partner to problem n=24

Participant	Differential	Self-report IELT (seconds)	Sex education	Partners reaction to problem
B	Acquired	<30	Trial and error	Physical
C	Lifelong	30-60	Trial and error	None
H	Acquired	120-180	Trial and error	Physical
I	Acquired	30-60	Trial and error	None
J	Acquired	30-60	Trial and error	Verbal
L	Acquired	Before penetration	Trial and error	Verbal
M	Acquired	On penetration	Trial and error	Verbal
R	Acquired	On penetration	Trial and error	Physical
X	Lifelong	On penetration	Trial and error	Physical
Y	Acquired	30-60	Trial and error	Verbal
A	Acquired	<30	Discuss with friends	Physical
O	Lifelong	On penetration	Discuss with friends	Physical
P	Acquired	<30	Discuss with friends	None
V	Lifelong	60-120	Discuss with friends	Verbal
W	Acquired	30-60	Discuss with friends	None
A2	Acquired	<30	Discuss with friends	Physical
D	Acquired	60-120	Porn	None
F	Acquired	On penetration	Porn	Physical
Q	Acquired	30-60	Porn	Physical
U	Acquired	30-60	Porn	None
T	Lifelong	<30	Porn	None
A1	Lifelong	On penetration	Porn	Verbal
G	Lifelong	Before penetration	Formal sex education	None
Z	Acquired	On penetration	Formal sex education	Physical

Table 5.36 Differential/self-report IELT, sex education, reaction of partner to problem (Lifelong) n=7

Participant	Differential	Self-report IELT (seconds)	Sex education	Partners reaction to problem
C	Lifelong	30-60	Trial and error	None
X	Lifelong	On penetration	Trial and error	Physical
O	Lifelong	On penetration	Discuss with friends	Physical
V	Lifelong	60-120	Discuss with friends	Verbal
T	Lifelong	<30	Porn	None
A1	Lifelong	On penetration	Porn	Verbal

Table 5.37 Differential/self-report IELT, sex education, reaction of partner to problem (Acquired) n=17

Participant	Differential	Self-report IELT (seconds)	Sex education	Partners reaction to problem
B	Acquired	<30	Trial and error	Physical
H	Acquired	120-180	Trial and error	Physical
I	Acquired	30-60	Trial and error	None
J	Acquired	30-60	Trial and error	Verbal
L	Acquired	Before penetration	Trial and error	Verbal
M	Acquired	On penetration	Trial and error	Verbal
R	Acquired	On penetration	Trial and error	Physical
Y	Acquired	30-60	Trial and error	Verbal
A	Acquired	<30	Discuss with friends	Physical
P	Acquired	<30	Discuss with friends	None
W	Acquired	30-60	Discuss with friends	None
A2	Acquired	<30	Discuss with friends	Physical
D	Acquired	60-120	Porn	None
F	Acquired	On penetration	Porn	Physical
Q	Acquired	30-60	Porn	Physical
U	Acquired	30-60	Porn	None
Z	Acquired	On penetration	Formal sex education	Physical

Muslim men commonly used the ‘trial and error’ discourse, or a variation of this when asked about sex education. Participant T stated that:

> "*because I am Muslim I have no sexual experience. My first encounter was when I was 20 years old, then nothing for 5 years. These periods of abstinence are causing the problem*."

Classical behavioural therapy involves masturbation but findings of the pre-research investigation indicated that masturbation was haram. Participants were asked 'How often do you masturbate?' which allowed participants greater freedom to develop responses (refer to tables 5.38, 5.39 and 5.40) rather than asking 'Do you masturbate'.

Table 5.38 Masturbatory practices, IELT, Differential, and reasons for not masturbating (all responses)

Participant	Differential	Self-report IELT (seconds)	How often do you masturbate?	Reasons why masturbation not done
D	Acquired	60-120	Never	Morally wrong
F	Acquired	On penetration	Never	Morally wrong
J	Acquired	30-60	Never	Wife would be unhappy
M	Acquired	On penetration	Never	Unnecessary, I am married
V	Lifelong	60-120	Never	Only young men do this
X	Lifelong	On penetration	Never	Unnecessary, I am married
Y	Acquired	30-60	Never	Morally wrong
A	Acquired	<30	Pre-marital	Wife would be unhappy
B	Acquired	<30	Pre-marital	Wife would be unhappy
C	Lifelong	30-60	Pre-marital	Causes PE
L	Acquired	Before penetration	Pre-marital	Unnecessary, I am married
O	Lifelong	On penetration	Pre-marital	Unnecessary, I am married
P	Acquired	<30	Pre-marital	Unnecessary, I am married
Q	Acquired	30-60	Pre-marital	Unnecessary, I am married
R	Acquired	On penetration	Pre-marital	Morally wrong
T	Lifelong	<30	Pre-marital	Morally wrong
W	Acquired	30-60	Pre-marital	Unnecessary, I am married
A1	Lifelong	On penetration	Pre-marital	Unnecessary, I am married
H	Acquired	120-180	Sometimes	n/a
A2	Acquired	<30	Sometimes	n/a
U	Acquired	30-60	Frequently	n/a
Z	Acquired	On penetration	Frequently	n/a
I	Acquired	30-60	Frequently	n/a

Table 5.39 Masturbatory practices, IELT, Differential, and reasons for not masturbating

Participant	Differential	Self-report IELT (seconds)	How often do you masturbate?	Reasons why masturbation not done
V	Lifelong	60-120	Never	Only young men do this
X	Lifelong	On penetration	Never	Unnecessary, I am married
C	Lifelong	30-60	Pre-marital	Causes PE
O	Lifelong	On penetration	Pre-marital	Unnecessary, I am married
T	Lifelong	<30	Pre-marital	Morally wrong
A1	Lifelong	On penetration	Pre-marital	Unnecessary, I am married

Table 5.40 Masturbatory practices, IELT, Differential, and reasons for not masturbating

Participant	Differential	Self-report IELT (seconds)	How often do you masturbate?	Reasons why masturbation not done
D	Acquired	60-120	Never	Morally wrong
F	Acquired	On penetration	Never	Morally wrong
J	Acquired	30-60	Never	Wife would be unhappy
M	Acquired	On penetration	Never	Unnecessary, I am married
Y	Acquired	30-60	Never	Morally wrong
A	Acquired	<30	Pre-marital	Wife would be unhappy
B	Acquired	<30	Pre-marital	Wife would be unhappy
L	Acquired	Before penetration	Pre-marital	n/a
P	Acquired	<30	Pre-marital	Unnecessary, I am married
Q	Acquired	30-60	Pre-marital	Unnecessary, I am married
R	Acquired	On penetration	Pre-marital	Morally wrong
W	Acquired	30-60	Pre-marital	Unnecessary, I am married
H	Acquired	120-180	Sometimes	n/a
A2	Acquired	<30	Sometimes	n/a
I	Acquired	30-60	Frequently	n/a
U	Acquired	30-60	Frequently	n/a
Z	Acquired	On penetration	Frequently	n/a

Many men described masturbation as against religious teaching or morally wrong despite the assurance from the Imam that masturbation for treatment purposes was acceptable/allowed.

In relation to the level of distress caused by PE, responses were correlated to duration of PE, number of children and the partners' reaction to the problem. The motivation for this was the discourse where participants claimed that production of male off-spring was of importance culturally (refer to tables 5.41, 5.42 and 5.43)

Table 5.41 Distress, self-reported IELT, number of children and partner response – all responses

Participant	Differential	Self-report IELT (seconds)	Number of children	Partners reaction to problem
A	Acquired	<30	2	Physical
B	Acquired	<30	4	Physical
C	Lifelong	30-60	0	None
D	Acquired	60-120	0	None
F	Acquired	On penetration	6	Physical
H	Acquired	120-180	2	Physical
I	Acquired	30-60	1	None
J	Acquired	30-60	1	Verbal
L	Acquired	Before penetration	4	Verbal
M	Acquired	On penetration	5	Verbal
O	Lifelong	On penetration		Physical
P	Acquired	<30	3	None
Q	Acquired	30-60	6	Physical
R	Acquired	On penetration	2	Physical
T	Lifelong	<30	2	None
U	Acquired	30-60	0	None
V	Lifelong	60-120	4	Verbal
W	Acquired	30-60	1	None
X	Lifelong	On penetration	4	Physical
Y	Acquired	30-60	4	Verbal
Z	Acquired	On penetration	2	Physical
A1	Lifelong	On penetration	3	Verbal
A2	Acquired	<30	2	Physical

Table 5.42 Distress, self-reported IELT, number of children and partner response (lifelong)

Participant	Differential	Self-report IELT (seconds)	Number of children	Partners reaction to problem
C	Lifelong	30-60	0	None
O	Lifelong	On penetration		Physical
T	Lifelong	<30	2	None
V	Lifelong	60-120	4	Verbal
X	Lifelong	On penetration	4	Physical
A1	Lifelong	On penetration	3	Verbal

Table 5.43 Distress, self-reported IELT, number of children and partner response (acquired)

Participant	Differential	Self-report IELT (seconds)	Number of children	Partners reaction to problem
A	Acquired	<30	2	Physical
B	Acquired	<30	4	Physical
D	Acquired	60-120	0	None
F	Acquired	On penetration	6	Physical
H	Acquired	120-180	2	Physical
I	Acquired	30-60	1	None
J	Acquired	30-60	1	Verbal
L	Acquired	Before penetration	4	Verbal
M	Acquired	On penetration	5	Verbal
P	Acquired	<30	3	None
Q	Acquired	30-60	6	Physical
R	Acquired	On penetration	2	Physical
U	Acquired	30-60	0	None
W	Acquired	30-60	1	None
Y	Acquired	30-60	4	Verbal
Z	Acquired	On penetration	2	Physical
A1	Lifelong	On penetration	3	Verbal
A2	Acquired	<30	2	Physical

Finally, table 5.44 indicates the impact of PE related to age, number of children and the self-reported impact of PE.

Table 5.44 ELT correlated with number of children and affects on relationship

Participant	Age	Est. ELT (s)	Differential	Children	Self report impact of PE
A	43	<30	Acquired	2	Depressed
B	41	<30	Acquired	4	Worried
C	25	30-60	Lifelong	0	Unhappy
D	37	60-120	Acquired	0	No problem
E	32	60-120	Lifelong	1	Depressed
F	47	0	Acquired	6	Depressed
H	53	120-180	Acquired	2	Unhappy
I	30	30-60	Acquired	1	Unhappy
J	34	30-60	Acquired	1	Worried
L	36	Before Penetration	Acquired	4	Devastated
M	59	0	Acquired	5	Unhappy
N	37	60-120	Acquired	0	No problem
O	53	0	Lifelong	0	Depressed
P	37	30	Acquired	3	Unhappy
Q	35	60	Acquired	6	Devastated
R	40	0	Acquired	2	Devastated
S	28	0	Acquired	0	Unhappy
V	38	120	Lifelong	4	Worried
W	31	120	Acquired	1	Devastated
X	42	0	Lifelong	4	Angry
Y	50	45	Acquired	4	Unknown
Z	31	0	Acquired	2	Depressed
A1	39	0	Lifelong	3	Devastated
A2	46	30	Acquired	2	Unhappy

The mainstay of behavioural therapy involves the couple, ideally where both parties attend the clinic for assessment and advice. Participant J, whose wife was a British Bangladeshi Muslim, stated that '*she wouldn't discuss sexual intercourse with anyone*'. Sexual activity can only be discussed with her husband, and then only in the bedroom. What is unclear is how this person knows what normal ejaculatory latency should be. This finding (that sexual function cannot be discussed) was reinforced by Participant S, who stated that Bangladeshi Muslim women will never discuss sexual activity with a third party, and certainly not with a male clinician:

"*Only men can do this, and only with other men. Sex can only be discussed in the confines of marriage and never to a third party. It is a private affair; if there is a problem, it is for the man to sort out on his own*."

Key points from cultural discourses

It is apparent from the narratives that there is little or no physical contact or intimacy outside of intercourse and so intercourse is the only time that affection/intimacy is shown. This may mean that the wife has a high demand for sexual activity, perhaps as much as every day, not because there is a high demand for sexual intercourse per se, but there is a demand for intimacy. It is unclear who instigates sexual activity, but from some of the results in relation to foreplay, it would seem that for some men, they simply demand intercourse in the absence of the feelings of their wife. Some participants indicated that intimacy is not shown anywhere outside the bedroom, and so intercourse may have an additional meaning in Muslim relationships, particularly where conforming to expected norms is strong, as exemplified by Participant E:

'*His wife was aware of his PE from their wedding night – he was unable to penetrate due to PE for 4 months. He felt that there was family and cultural pressure to have a child. Interestingly, his partner (a British Bangladeshi) was adamant that she would not leave him, stating that "she knew that he was doing his best and she loved him". She was advised by a doctor in a private clinic (UK English doctor) that her husband would never get better. She stayed with him, aware that PE was sufficient grounds for divorce*.'

All of the married Bangladeshi Muslim men had arranged marriages. Prior sexual (intercourse) experience was low, with 34% of participants only having one sexual partner (their current wife). There were no reports of polygamy and only one man reported pre-marital homosexual activity on (4 occasions but 'nothing since marriage'). 85% had no pre-marital sex and sex education seems to be limited to "*trial and error*", "*information from friends*" and "*porn*",

leading to the conclusion that many men had unrealistic expectations about normal sexual activity, or more accurately, the time ranges for normal sexual activity.

The question: 'When having sexual intercourse, is the man always on top?' indicated marked differences in responses that seemed to be dependent on levels of education and country of origin. For men whose partners were from Britain, they were much more likely to engage in different positions/activities for sex, whereas those from Bangladesh, particularly those from the Sylhet region, were much more reluctant in engaging in alternative forms of activity. British Bangladeshi Men and British Bangladeshi women, or that is men and women raised in the UK but from a Bangladeshi background, were more likely to engage in alternative forms of sexual practice. They also understood their sexual and relationship needs, irrespective of whether children had been produced.

The causes of PE were usually answered with "*don't know*" or similar responses. Nevertheless, some men tried to explain their condition in biological terms, for example, loose nerves, weak blood, cold weather, diabetes mellitus and masturbation. Some participants were at great pains to explain (and therefore to be given), a physical cause to their problem, and almost universally medication was wanted as a means for cure. A structured vignette was devised during the research for those who stated '*don't know*' to causation of PE. They tended to agree with the statements related to physiology (cold climates, weak blood, etc.) and all universally agreed that masturbation had some causal relationship to the development of PE.

When asked whether masturbation was continued after marriage, most men said that they no longer engaged in the activity because "*they were married*". A common narrative was "*why should I masturbate? I have a wife, when I want sex I tell her*". Indeed, most men were incredulous that they were asked how often they masturbated. Some continued to engage in masturbation, but these men had grown up in the UK and tended to be less orthodox in their religious observance, evidenced by infrequent attendance at the mosque;

occasional prayer; or limited observance of Ramadan. In some cases, the Koran was used as a justification for not masturbating, with statements such as "*it is morally wrong*" or "*sinful*" or "*against his religion*".

Summary

The main findings of the research are that there are three themes that operate in the construction and knowledge of PE. These are biomedicine, psychology and culture. Each theme has sub-themes that cut across these main themes. The sub-themes are time; definition; construction of norms; acceptable treatment options; the man's expectations; and the partner's expectation of normal sexual activity.

Biomedical factors that contribute to help-seeking behaviours are changes in post ejaculatory recovery time rather than the absolute ejaculatory latency time. The severity of PE did not correlate to ELT, and participants in this research only became concerned with ejaculatory control once their PERT had lengthened. It was difficult to position men using the differential feature of PE (lifelong/acquired) due to the lack of sexual experience and pressure to perform roles (sexual as well as social).

The psychological theme indicated that there was sexual naivety amongst Bangladeshi men, but there was pressure to perform normally (however that was defined by the individuals) right from the beginning of their sexually approved (i.e. within marriage) relationships. The Bangladeshi men did not express desire to enjoy sexual activity, rather they wanted to achieve a time-focussed delay as their goal. Furthermore, men were keen for biomedical explanation of PE rather than learning behavioural techniques that may assist in ejaculatory delay. These findings indicate a cognitive separation between mind and body, where the body had to perform irrespective of how the man felt about the relationship.

In the cultural theme, the majority of marriages were arranged and there was little or no premarital sexual activity with another person, and very limited

masturbation. There was a difference in the narratives between Bangladeshi men who were brought up in the UK, and native Bangladeshi men. This latter group can be further sub-divided into Sylheti and non-Sylheti men. Sylheti men demonstrated further separation between mind and body, and were keen to explain PE in terms of biomedical trouble exclusively. Any mention of behavioural intervention would elicit a response that drew on the Koran to explain why non-penetrative sexual practices were impossible.

Rather than comment on the overall educational attainment of the Bangladeshi men, the level and depth of sex education that these men were exposed to was explored. From the responses given, no formal or informal sex education was provided. The significance of this is exemplified by the need for procreative sexual activity and the production of children during early marriage. In the absence of any knowledge of normal sexual function myth and unrealistic expectations were prevalent, evidenced by the imagined desirable ejaculatory delays.

In the chapter that follows, Part 1 of the discussion is explicated in relation to the problem spaces inherent to the research project. Part 2 extends this discussion and engages in discourse associated with the limitations of the research.

Chapter 6

Discussion Part 1: Problem spaces as a means of categorisation

Introduction

Chapter two reviewed the literature and provided a point of entry to the thesis by grouping together four hegemonic discourses used in premature ejaculation, i.e. prevalence, definition, aetiology and treatment. These discourses relate to behaviours and experiences which have been 'rationalised, theorised and codified' (Rose, 1998: 61). In this chapter, the concept of 'problem spaces' is introduced as a means of interpreting these discourses. These discourses will be used as a means of categorising the results.

These hegemonic discourses however are not value or culture-free; consequently, they have been deconstructed into problem spaces. There are six problem spaces (Oster, 2003) which allow further examination of the relationship of the literature to both the research and the participants discourses.

Problematisations

Problematisations are defined as 'the everyday practices where conduct has become problematic to others or oneself' and attempts to 'render these problems intelligible and, at the same time, manageable' (Rose, 1998: 26). The fundamental tenet of problematisations is the operation of power, in this case, rendering PE, and the people affected by it (the man and/or his partner). A problem also locates these objects of problematisation within particular forms of knowledge and regulation (medicine, psychology and religion).

The focus of this thesis is on the ways in which men with PE, as individuals *within* whom the condition is located and *through* whom it is transferred to others, are regulated by being problematised in certain ways.

Analysis of power from a Foucauldian perspective explores micro practices of power (Dreyfus and Rabinow, 1982), the *local* rather than *global* operation of power, which is important when considering how religion is cited as a reason for an inability to engage with certain treatments, or as an explanation for divorce, i.e. the inability to meet the needs of the family unit. Furthermore, being labelled as a premature ejaculator enmeshes people with the condition in various local webs of power relations (refer to extract from field notes with Imam).

In an essay titled 'The subject and power', Foucault discussed how a person could analyse power relationships. In the discussion he stated:

> One can analyse such relationships, or rather I should say that it is perfectly legitimate to do so, by focussing on carefully defined institutions. The latter constitute a privileged point of observation, diversified, concentrated, put in order, and carried through to the highest point of their efficacy. It is here that, as a first approximation, one might expect to see the appearance of the form and logic of their elementary mechanisms. (Foucault, 1982: 222)

Discourses, defined by Foucault as 'practices that systematically form the objects of which they speak', (Foucault, 1972: 42), are critical in understanding the meanings of PE; they are the means through which the premature ejaculator "speaks" of itself to itself (Danaher, et al. 2000: 33). Within these discourses men with PE become a problem for regulation, because 'something doesn't become a problem until it enters a discourse' (Danaher, et al. 2000: 39). But entering into discourse *makes* the person *visible*: he must confess his symptoms to the medical/psychiatric authority to get his condition validated and treated.

An unplanned result of this research was that patients themselves deployed three main discourses (medical, psychological and cultural) in their narratives to explain PE during their clinical encounters. By using the six problem spaces, i.e. linearity, terminology, time, the clinic space, clinician/researcher and culture, (refer to figure 1, page 19) the results can be categorised to further illustrate the competing discourses, which seek to own and influence clinical management and understanding of PE.

A. The linearity of the thesis document

Most written documents or stories have a defined or clear beginning, middle and end, and subsequently are linear in structure. The first problem space is the linearity of the thesis itself. The initial literature review was conducted in 2002 and refined shortly before the project was submitted for Ethical approval in 2004. As a result some of the assumptions made at the beginning of the research, for example, definition of PE and differential features (lifelong and acquired), may no longer be valid for this group of men. Furthermore, as a result of conducting this research, and after reviewing subsequent papers (see Richardson and Goldmeier, 2005; Nicolosi, et al. 2005; and Frewen, et al. 2007), it would have been preferable to restrict the inclusion/exclusion criteria to non-Muslims, or indeed Muslims only, to further allow exploration of the cultural influences of PE to be examined. This was initially attempted, but was rejected by the Ethics committee because it was too limited to one particular group.

The texts for analysis were produced directly from transcribed clinical encounters and are influenced by different factors, for example, the gender of the researcher, the current status of the relationship (between patient and partner), and the expected outcomes of treatment. All of these factors are in essence the middle part of the thesis and potentially affect the interpretation of the discourses. For example, the man with PE already has an interpretation and meaning of the phenomenon, and has attempted to rationalise the experience over time. When interviewed as part of the research, his responses were influenced by the man's relationship with his partner, and the

expectations of normality that exist for him at that moment in time. Although these tensions and issues will be discussed within thesis, it can only represent a moment in time, and therefore the thesis itself cannot have a 'beginning' or an 'end' but only a summary of the analysed data for a particular contemporary time.

The quantitative and qualitative data has been separated out for the purposes of the thesis, but in reality they are interdependent and should be viewed as a whole. Many clinical reports discussed in the previous sections exclude the voice of the patients, and so the thesis will specifically re-unify these voices. The thesis document itself is therefore a problem space in which all aspects of the document are intentionally constructed to produce meanings using a particular theoretical perspective (i.e. medicalisation and governmentality) discussed in chapter three.

B. Terminology

The language used to explain the phenomenon of PE is not neutral, indeed the term premature suggests an earlier than normal event but there is no universally accepted definition of normal ejaculatory latency. The competing definitions that seek to either describe or qualify PE have been described, but in summary, from a psychological perspective premature ejaculation occurs before the person (or his partner) wishes it, whereas from a medical perspective, severe premature ejaculation is defined as an intravaginal ejaculatory latency of less than 1 minute (Lue, et al. 2004). What is clear within the definitions is that time, which is a problem space itself, is becoming more important, not the experience or the impact that this syndrome has on the individual.

The terminology used in this thesis is also a problem space in that it has a meaning to the person with the condition, just as much as it has a meaning as it relates to definition and diagnosis of the syndrome. In this research a standard protocol and terminology were used to promote consistency and allow external analysis and checking of the data. The decisions regarding

what terminology was (or was not) used, along with the definitions used to qualify the syndrome are in themselves not neutral or value-free. The acronym PE is used as it is the currently accepted term in much of the literature, although alternatives of rapid ejaculation or early ejaculation are found. Furthermore, PE is the preferred term in the clinic involved with the research because most of the referrals and discussions with other clinical colleagues use this abbreviation, rather than rapid ejaculation or RE (which is usually taken to mean retarded ejaculation).

C. Time

The acronym IELT/ELT refers to intravaginal ejaculatory latency time/ejaculatory latency time. This term is used in the main body of the text to indicate an allegedly objective measure of the time it took (on average) for men to ejaculate. IELT is measured at home using a stopwatch, but this is in itself problematic for several reasons. Firstly the assumption (both in essence and in the literature) is that couples are heterosexual and engage in vaginal intercourse only. There are no published reports or comments that indicate alternative measuring sites, for example anal or oral. In the literature, some researchers advocate counting the number of thrusts (refer to Rowland, et al. 2001), but this has been largely rejected as an unscientific measure (refer to Waldinger, 2003) because the intensity and frequency of thrusts are not usually recorded (or remembered) and leads to criticisms of having intercourse by numbers. The second problem is that using a stopwatch during intercourse may distract the man (and/or his partner) from the subjective experience of intercourse. Thirdly, the relationship which is usually under strain due to PE, has to accept the stopwatch as part of the encounter, and finally there is an explicit assumption that the readings will be accurately reported by the participant.

As Foucault argued, the concern in the increasing categorising of sex, sexual identities and functions has produced a *Scientia Sexualis,* in Western culture at least, to replace earlier 'procedures for producing the truth of sex' (1979:57), which he identifies as the A*rs Erotica*.

> ‘In the erotic art, truth is drawn from pleasure itself, understood as a practice and accumulated as experience, pleasure is not considered in relation to an absolute law of the permitted and the forbidden, nor by reference to a criterion of unity, but first and foremost in relation to itself: it is experienced as pleasure, evaluated in its intensity, its specific quality, its duration, its reverberations in the body and the soul. Moreover this knowledge must be deflected back into the sexual practice itself, in order to shape it as though from within and amplify its effects’ (Foucault, 1979:57).

The measurement of IELT therefore potentially reduces sexual activity to a science, rather than an art, and so sexual activity becomes a goal-directed performance rather than an enjoyable, intimate and affirming activity. As such, the sexual encounter is the subject of increased medicalisation, which can be defined as a “process of increased medical intervention and control into areas that hitherto would have been outside the medical domain” (Bilton, 1996), with its concomitant assumptions, that is a problem is defined in ‘medical terms, using medical language to describe the problem, adopting a medical framework to understand a problem, or using a medical intervention to “treat” it’ (Williams, 2003).

Time in the context of this thesis, refers to both scientific measures of success or failure and subsequent qualification of the syndrome by using stop-watches. An extract from the field notes (refer to table 6.1), exemplifies the problem space of time and the expectations of normal sexual activity. Both concepts will be discussed further, but the extract is included here to forewarn the reader of the complexity and contradictions that exist in understanding PE from diverse perspectives.

Table 6.1 Extract from field notes illustrating expectations of normality and the cultural pressures to perform

Respondent: “Two men were [each] divorced within one week of marriage. Researcher: Why was that? Respondent: They had premature ejaculation. Researcher: What happened to the couples, were they offered help? Respondent: No. Sex is a taboo subject and will not be discussed outside marriage. The wives were able to get divorces because they were unsatisfied in their sex lives. The ex-wives explained the quick divorce to the local community by saying that the men had terminal cancer… Researcher: Oh,…. Respondent: The men disappeared from the local area…I don’t know where they went. Of course, these men were disabled and should not have got married. Disabled men should not get married”.

Patient discourses are often focussed on time as an end point for sexual activity, rather than enjoyment or satisfaction with the act itself. The time element is therefore a central and recurring theme.

D. Clinic space

The term Sexual Dysfunction clinic is used to refer to a nurse-led clinic that is a location for the diagnosis, treatment, and provision of information and advice about premature ejaculation. The clinical room used for discussions about PE is also used for urethral and suprapubic catheterisation, electrocardiogram recording, pre-admission and administration of intravesical chemotherapy, and for that reason contains varying amounts of clinical equipment.

All clinical encounters are conducted in a defensive/protective manner since the physical space doesn’t allow re-orientation of the furniture; this can also be construed as reinforcing the unique otherness of the client by not allowing him to be positioned as an equal in the discussion.

The term client/patient is used predominantly in this thesis instead of using one or the other of these terms. The term client has emerged relatively recently with a shift in the ideology of health provision towards a more service-based, consumer-focused industry. The term patient, in contrast, is

understood within this ideology as a denigrating term that reflects an unequal power relationship between health professionals and their clients/patients.

These distinctions also serve another purpose; some patients prefer to adopt a passive, doctor-knows-best approach, and are demonstrably uncomfortable when asked to participate in the decision-making for their treatment. To illustrate this, patient A2 was at great pains to say how he liked being in England because "*in England you have very good medicine and very good doctor who knows what is best…….this is not the same at home [Bangladesh], so you tell me which is best medicine*". This is of importance and exemplified some of the cultural influences that patients bring to the clinic space. It is essential to understand patient's religious and cultural background. For patients from a patriarchal society, they may see collaboration between patient and clinician as the clinician not knowing what to do. The cultural dimension will be explored in the discussion (culture) section.

An additional element of problematisation in the research is that the men are referred by clinical colleagues and are absorbed into the fabric of health service administration. The absorption into an established healthcare setting created an additional problem, one where patients were afraid that their narratives would somehow become known by their local community. This was particularly evident in Bangladeshi men, and for one patient/client, he came back to the clinic after his initial consultation (with a health advocate in attendance) after he had hidden in the toilet waiting for the health advocate to leave. Once the advocate left, the patient/client came back to the consulting room and proceeded to give an entirely different history. In this case, his fear was that someone from his own culture and religion would find out that he had masturbated as a young man.

Many patients/clients needed reassuring that their names would not be used in the research, and said that they were reassured that an anonymous designation system would be used to add an additional layer of security and confidentiality. In this thesis, patients/clients have been referred to using their

letter designation rather than their names or initials. This also clarifies the analysis since several participants shared initials or surnames.

These examples of terminology used in this thesis demonstrate that the choice of how to present a phenomenon, a person or a place, is a value judgement and shapes the meanings produced in the corpus of the text. The problematisation of the linearity of the thesis and of the terminology used in this thesis demonstrate that such a construction of knowledge is not itself value-neutral.

E. Clinician/researcher

The literature review indicated gaps in knowledge, specifically the influence of culture on interpretation of PE and ability to engage in certain treatments, and therefore the aims of the research were to explore permissible sexual activities, identification of barriers to treatment, and to identify how Bangladeshi Muslim men construct knowledge of PE. However, because the research was grounded in clinical practice, it was not possible to be a neutral observer of how men behaved. The problem space with the clinician as researcher is therefore a potential conflict of interest. For example, the researcher may lose objectivity between what is being said and what is interpreted as a true narrative. Finally, when analysing the data, the clinical implications of what was said inevitably affected part of the interpretation of the data, rather than the data being interpreted from a neutral perspective.

F. Knowledge(s) (culture)

The appropriate management of sexuality is problematic for people and is largely dependent on the successful performance of their roles in their interactions with others in everyday life. The narratives from patients who attend the clinic include statements such as “my wife sent me to get cured” and “she will divorce me if I don’t get it sorted”, which indicates that for some

men at least, their performance meets their expectations but not their partners.

Simon and Gagnon (1999) originated the notion that individuals employ scripts which are metaphors for conceptualising the production of behaviour in social life. These scripts allow men to interpret their sexual roles, particularly within a cultural context. Drawing on this notion of sexual scripting, sexual behaviour can be conceptualised in three key domains:

1. Collective and cultural meanings of sex, the erotic and its regulation;
2. The interpersonal, 'capillary-level' conduct of sexual practices;
3. Individual, or intrapsychic, fantasy and symbolic constructions of the self and sexual identity.

These domains can be re-conceptualised back into biological or physiological dimensions of sex, exemplified when the body does not enable the fulfilment of a satisfactory performance of the sexual role through dysfunction or premature ejaculation. The *context* of the encounter and the *meaning* for the individual (and couple) is therefore different and specific for that moment (Berne, 1993).

The prevalence data presented indicates a potential cultural factor of premature ejaculation, often evoking a sense that cultural differences are an otherness and therefore an exotic difference from Western normality (Sumanthipala, et al. 2004). However it is important to acknowledge that culture is dynamic and fluid, at least to the individual embedded within it, and not a reductive otherness in which all behaviours are deemed to have equal meaning for the participant (Pollen, 2001). Furthermore, medicine and psychiatry can be considered cultures in themselves, therefore the cultural and historical perspectives are important to elucidate, since it is the status of these perspectives that accord value, and therefore validity, for defining this condition.

Historically semen anxiety loss has been referred to as a culture-bound syndrome, a term used to describe the uniqueness of some syndromes in specific cultures. Dhat (semen-loss anxiety) has been considered to be an exotic neurosis of the Orient (particularly in India), although this definition is erroneous since all definitions are bound within their own cultural construct (Sumathipala, et al. 2004). Littlewood and Lispedge (1985) suggest that at best culture-bound syndromes are vague entities. Hughes (1996) proposed that these cultural discourses form a unique and distinctive class of generic phenomena, and that such syndromes exist among and afflict only the others – people who by some criterion are outside the mainstream population (however that is defined) (Sumathipala, et al. (2004).

Prince and Tcheng-Laroche (1987) emphasise that four facets of culture-bound syndromes must be taken into account when exploring them; these are:

- Accidents of geography (i.e. a disorder may be present in some cultures but not in others for geographical rather than social reasons);
- Designation (some illnesses are considered culture-bound simply because they happen to have local names);
- Epidemiological differences (global prevalence rates, variations in gender ratios and age at onset may be used in assigning culture-bound status);
- Symptom differences themselves do not add to the differentiation of diagnosis

The contention by Sumathipala, et al. (2004) is that symptoms, syndromes and their management must be embedded in *local* cultures in order to help clinicians. What is missing from the literature therefore is an acknowledgement of the *culture* of the local population from which participants are drawn.

Premature ejaculation

From a medical perspective, the problem spaces associated with PE are formulated predominantly in the unavailability of a clear agreement on definition or a medical cure for the condition (Lue, et al. 2004). Further features of PE are whether lifelong (in all situations) or acquired or episodic. Thus, once the condition is diagnosed there are difficulties in knowing which treatment to offer. There are, however, medical options available for treatment, including selective serotonin re-uptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), atypical tricyclic antidepressants, lidocaine (lignocaine) sprays and creams that are applied to the glans penis, that have varying degrees of scientific success which are defined as a delay in IELT, but if the patient ceases to take them there are no long-term delays with these options and men go back to baseline IELT measures. Furthermore, in the case of SSRIs, etc., they are not licensed for treatment of PE and can have unpleasant side effects, for example, nausea, drowsiness, perspiration (commonly) and less commonly bleeding, decreased blood glucose and low sodium (Fallon, 2008).

From a psychological perspective, PE encompassed in the six problem spaces is subsequently a dilemma in that the reported prevalence is rising worldwide, increasing the demand for psychosexual counselling at a time where provision of psychosexual counsellors, at least in the NHS, is limited. Behavioural therapies rely on masturbation, which is a practice that is not value-free but something that is shrouded in taboo. Furthermore, traditional sex therapy in the form of sensate focus, behavioural or sex therapies have not found the hoped-for long-term cures (De Amicus, et al. 1985).

A further perspective from which PE is rendered problematic is culture. This is a much more dense and impenetrable perspective to explicate but incorporates expected gender norms, the function of the family, and performances that are bound up in the overarching theme of religion or religious belief. The power of semen is something that has appeared to concern civilisation for centuries, and these concerns have been absorbed

into the popular consciousness; particularly in relation to inappropriate semen loss.

To explore this powerful and pervasive discursive element around the physical and symbolic role of semen, additional sources of data collection were incorporated into the research process. PE represents a form of inappropriate semen loss, from the inability to deposit semen in the correct place to fertilise ova, or to satisfy the partners' sexual desires. For some men, sexual activity has importance in cultural terms, by stabilising the family unit, production of children, etc. which are considered as paramount importance in some religions. Failure to perform has drastic consequences in terms of divorce, but also in labelling as disabled which renders these men unable to perform in their wider social roles.

The current quantitative and qualitative literature has not provided much needed contextual insights into the experiences and meanings of PE to men from various cultural/religious backgrounds. In this research, the majority of men are from a Bangladeshi Muslim background, and these men may have additional pressures to conform to expected traditional norms whilst at the same time being exposed to Western concepts of normal sexual behaviour which may be culturally unacceptable (Richardson and Goldmeier, 2005). To further illustrate this concept, an example of cultural pressure to conform to normality is provided by Blake and Katrak (2002:192):

> "Marriage is the expected state for adults. Sexual activity must bring equal fulfilment to both partners – this is the basis to raise a family and is the basis of Islamic 'social' structure"

The vast majority of the existing research and literature on PE is located in the medical and psychiatric perspectives. Furthermore, medical and psychiatric perspectives on PE are presented as objective, scientific, and value-free approaches for exploring the problems associated with the condition. Yet these perspectives on PE are not neutral; they are instead value-laden, bringing with them a history of taken-for-granted assumptions about the

nature of human experience and behaviour. The medical and psychiatric perspectives for exploring or understanding the problem space of PE are in fact apparatuses within which this problem space is rendered intelligible and thereby manageable. As Rose points out:

> Such apparatuses…are normative, and hence sensitive to deviation. They provide the focus for the activity of authorities – such as the medical profession – who will scrutinise and adjudicate events within them. And they are the locus for the application of certain grids of specification for dividing, classifying, grouping, and regrouping the phenomena that appear within them (Rose, 1998: 61).

The normative apparatuses of medicine, psychiatry and culture/religion are locations in which PE and sexual activity are problematised so as to render it amenable to regulation. Such an understanding of the existing approaches to the problem of PE forms the backdrop to the formulation of the approach to the regulation of men with PE that has been adopted in this thesis.

Summary

There has been a change in emphasis in the clinical management of PE from a behavioural approach to a medical one, using SSRIs to control ejaculation times. Behavioural therapies have been rejected by many clinicians and patients alike. PE is becoming stratified by time measures based on normative values and ‘normal’ heterosexual vaginal intercourse, which may bear no relationship to actual sexual practices.

Discussion Part 2:

Introduction

The aims of the research were to identify:

- What are the norms of sexual activity in Bangladeshi Muslim men with PE?
- What are the barriers to discussing sexual activity and engaging in treatments for PE?
- How do Bangladeshi Muslim men construct knowledge of PE?

Using thematic analysis and the theory of Foucault, the results of this research have shown how medicalisation constructs knowledge of PE and how disciplinary practices reinforce the knowledge of the condition. This has been shown in two ways; the first is through an analysis of the biomedical/psychological literature and the second is by the narratives used by Bangladeshi Muslim men attending the clinic. What is of interest here is exploring how medicalisation of PE is understood by Bangladeshi Muslim men.

Foucault's work on governmentality offers an alternative means of interpreting the world from the current positivistic biomedical model that is rooted in modernism. Modernism views knowledge and truth as neutral and objective. The written texts from Waldinger (1998; 2002; 2003; 2004; 2007); Porst, et al (2007); Jannini and Lenzi (2005); Jannini, et al. (2006) and Jannini (2007) exemplify the current positivistic biomedical model that uses scientific rationality and reductive practices to understand PE.

The Biomedical Theme (texts and narratives)

The biomedical theme comprises discourses (texts) related to prevalence, aetiology, definition and treatment. Each text and discourse relates to a

problem space, which is a particular area of conduct that renders these problems intelligible and manageable (Rose, 1998: 26). Furthermore, the key element of problem spaces is the operation of power. The prevalence of PE or the knowledge of how common PE affects men, has been drawn from Internet Surveys and large multi-centre epidemiological studies, indicating that PE occurs in 22.7% of sexually active men. But what does this data actually say? It states that in the small minority of men who are willing to enrol in epidemiological studies or Internet Surveys, a large number report PE based on poorly defined criteria. It says nothing about their constructs of normal sexual activity or of any cultural issues that may influence men. What the results of this research indicate is that, for many Bangladeshi Muslim men, access to seeking treatment is limited to those whose relationships are breaking down, where partners are threatening their husbands with removal of children, or with physical violence, because of PE. Thus, the *context* of the condition is missing from the prevalence data, which therefore reduces the prevalence data to a simple, reductive number. This finding illustrates the new knowledge that this research contributes to the collective understanding or PE.

Biomedical reports speculate on aetiology and whilst acknowledging that the aetiology of PE is poorly understood, dominant theories, i.e. biomedical theories, are emerging that seek to position individuals in certain places, not based on subjective experiences, but based on quasi-scientific data and theories related to neurobiological phenomena. As discussed in chapter two, the latest theories are becoming centred around the differential feature of PE, i.e. whether lifelong or acquired PE. For Waldinger, lifelong PE is a primary neurobiological process, but for Rowland and Stewart (2005) there are elements of neurophysiology *and* learnt behaviours that coalesce into the phenomena of PE; particularly for those with acquired PE. The data from the participants in this research could be interpreted in several ways, depending on point of view and philosophical perspective. Of the 23 Bangladeshi participants 6 were classified as lifelong premature ejaculators and 17 were classified as acquired premature ejaculators. The classification was based on whether the men had always ejaculated before they wanted to, which means

with every partner, or whether they seemed to have a change in ejaculatory latency from an earlier point in time. This therefore assumes that men a) have had more than one sexual partner, and/or b) that they engage (or have engaged in) masturbation. For Bangladeshi Muslim men, 6 reported never having masturbated and 11 reported that they only engaged in masturbation before marriage. The salient fact is that for between 6 and 19 men (out of 23), they are either unable or very unlikely to be able to know whether they have always ejaculated before they wished to or not. Masturbation is not about extending sexual pleasure for someone else's enjoyment, but about solitary activity where no partner is there to criticise or comment on the ejaculatory delay. Thus, for most of the Bangladeshi Muslim men, it was difficult to accurately position them as either lifelong or acquired premature ejaculators, which calls into question the relevance of the differential feature of PE. Furthermore, and as illustrated in table 5.23, 4 men felt that it was morally wrong (or against their religion) to masturbate and another 1 participant felt that masturbation actually caused PE, so in addition to a questionable differential feature, there is an assumption that men will know their normal ejaculatory latency from either pre-marital sexual activity or masturbation, neither of which many participants of this research engaged in. What this again illustrates is the reductive nature of clinical reports, particularly those related to epidemiology, aetiology or acceptable treatment options. Additional assumptions are that a) individuals are heterosexual, b) they are sexually active before marriage, and c) that masturbation is an acceptable activity that is not judged in a stigmatising way.

At the inception of the research there was no consensus definition of what constitutes a diagnosis of PE (or indeed whether to call it early, premature, or rapid ejaculation). The two contemporary definitions were drawn from the American Psychological Association (DSM-IV) and the International Classification of Diseases (ICD-10) and subsequent amendments to both definitions included a measure of time (usually stopwatch-assessed) of ejaculation in less than 2 or 3 minutes after intromission (sometimes vaginal intromission was the preferred term).

Recently, the definition of lifelong PE has been the subject of a consensus committee of the International Society for Sexual Medicine (McMahon, et al. 2008). The consensus agreement is that lifelong PE is characterised by:

- Ejaculation which is always or nearly always occurs before or within about one minute of vaginal penetration, and
- The inability to delay ejaculation on all or nearly all vaginal penetrations, and;
- Negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy.

The committee agreed that the 1 minute IELT threshold is not in itself an absolute criteria for diagnosis, stating that approximately 10% of lifelong premature ejaculators have IELTs between 1 and 2 minutes (McMahon, et al. 2008). The committee also acknowledged the limitations of this definition; specifically its heterosexual application in men engaging in vaginal intercourse. The rationale for the limitations in the definition is explained by the paucity of studies in homosexual men, or indeed alternative sites of sexual activity. Furthermore, the committee were unable to draw an acceptable definition of acquired PE, citing a lack of evidence-based objective data from which to craft a definition.

Although this definition is based on an evaluation of published data there remains an implied assumption that the men will be able to time ejaculation and that there is no extraneous pressure from partners (or expectations from the culture) that impose sexual norms on individuals.

In view of this new definition of lifelong PE, the responses from participants were reviewed and correlated with the criteria suggested by the Ad Hoc ISSM committee. The correlations are in table 6.2, which provides an overall summary, and then has been broken down into those with, possibly, lifelong PE (table 6.3) and acquired PE (table 6.4).

Although the ISSM PE characteristics seek to differentiate between lifelong and acquired PE, there remains a reliance on either the patient to be a good historian of his own sexual function, or of the clinician to be able to elicit a history of the condition that would allow categorisation into lifelong PE or non-lifelong PE.

Participants	No of Children	Differential	ELT	Inability to delay	Nocturnal emissions	Negativity	Index of - negativity
Y	4	Acquired	<60	Yes	No	Yes	Data missing
A4	Data missing	Acquired	<60	Yes	Yes	Yes	Data missing
L	4	Acquired	<60	No	Yes	Yes	5
Q	6	Acquired	<60	Yes	Yes	Yes	5
R	2	Acquired	<60	Yes	Yes	Yes	5
X	4	Lifelong	<60	No	No	Yes	5
A1	3	Lifelong	<60	Yes	Yes	Yes	5
A	2	Acquired	<60	Yes	No	Yes	4
E	1	Lifelong	60-120s	Yes	Yes	Yes	4
F	6	Acquired	<60	Yes		Yes	4
O	Data missing	Lifelong	<60	Yes	No	Yes	4
Z	2	Acquired	<60	Yes	Yes	Yes	4
C	0	Lifelong	<60	Yes	No	Yes	3
H	2	Acquired	120-180	Yes	No	Yes	3
I	1	Acquired	<60	No	No	Yes	3
M	5	Acquired	<60	Yes	Yes	Yes	3
P	3	Acquired	<60	Yes	Yes	Yes	3
S	0	Acquired	<60	Yes	Yes	Yes	3
W	1	Acquired	<60	Yes	No	Yes	3
A2	2	Acquired	<60	Yes	Yes	Yes	3
A3	Data missing	Acquired	<60	No	No	Yes	3
B	4	Acquired	<60	No	Yes	Yes	1
J	1	Acquired	<60	No	Yes	Yes	1
V	4	Lifelong	60-120s	Yes	Yes	Yes	1
D	0	Acquired	60-120s	Yes	Yes	No	0
N	Data missing	Acquired	<60	Yes	Yes	Yes	0

Table 6.2Correlation using ISSM variables for diagnosing Lifelong PE (all participants)

Participants	No of Children	Differential	ELT	Inability to delay	Nocturnal emissions	Negativity	Index of - negativity
X	4	Lifelong	<60	No	No	Yes	5
A1	3	Lifelong	<60	Yes	Yes	Yes	5
E	1	Lifelong	60-120s	Yes	Yes	Yes	4
O	Data missing	Lifelong	<60	Yes	No	Yes	4
C	0	Lifelong	<60	Yes	No	Yes	3
V	4	Lifelong	60-120s	Yes	Yes	Yes	1

Table 6.3 Correlation using ISSM variables for diagnosing Lifelong PE (participants whose history indicated lifelong PE using DSM-IV/ICD-10 criteria)

Participants	No of Children	Differential	ELT	Inability to delay	Nocturnal emissions	Negativity	Index of - negativity
Y	4	Acquired	<60	Yes	No	Yes	Data missing
A4		Acquired	<60	Yes	Yes	Yes	Data missing
L	4	Acquired	<60	No	Yes	Yes	5
Q	6	Acquired	<60	Yes	Yes	Yes	5
R	2	Acquired	<60	Yes	Yes	Yes	5
A	2	Acquired	<60	Yes	No	Yes	4
F	6	Acquired	<60	Yes		Yes	4
Z	2	Acquired	<60	Yes	Yes	Yes	4
H	2	Acquired	120-180	Yes	No	Yes	3
I	1	Acquired	<60	No	No	Yes	3
M	5	Acquired	<60	Yes	Yes	Yes	3
P	3	Acquired	<60	Yes	Yes	Yes	3
S	0	Acquired	<60	Yes	Yes	Yes	3
W	1	Acquired	<60	Yes	No	Yes	3
A2	2	Acquired	<60	Yes	Yes	Yes	3
A3	Data missing	Acquired	<60	No	No	Yes	3
B	4	Acquired	<60	No	Yes	Yes	1
J	1	Acquired	<60	No	Yes	Yes	1
D	0	Acquired	60-120s	Yes	Yes	No	0
N	Data missing	Acquired	<60	Yes	Yes	Yes	0

Table 6.4 Correlation using ISSM variables for diagnosing Lifelong PE (participants whose history indicated acquired PE using DSM-IV/ICD-10 criteria)

Taking the results from those who were initially classified as having lifelong PE, it is evident that, for this very small sample, 66% had and ELT of < 60 seconds; 83% were unable to delay ejaculation on all or nearly all penetrations; 50% had nocturnal seminal emissions; 100% had negative personal consequences, but the severity of these personal consequences were extremely variable (from being worried about the condition, to being

devastated by it). The contention is although the new definition of lifelong PE is based on evidence from clinical reports, from the results in this research the clinical reports do not meet with patient's subjective experiences. As indicated in table 5.11, participants are extremely worried about their condition, and in many cases their partners are less than supportive to them, which will result in increased pressure to perform, and so it is more likely that men will ejaculate early due to performance anxiety.

Examining the data from men who were initially classified as having acquired PE (table 5.3) 90% had ELTs of less than 60 seconds; 75% couldn't delay ejaculation; 65% had nocturnal emissions; 95% had some negative personal consequences, and for all but 2 of these participants, the negativity ranged from worried to devastated. In fact, there is little discernable difference between those positioned initially as suffering from lifelong PE or acquired PE. From the results of this research, it would seem that assigning the characteristic of lifelong PE or acquired PE is based on patient report of his sexual activity, on his subjective experience of the impact of PE and on the utilisation of language to explain PE in such terms. In terms of clinical management, certainly those men who were positioned as having lifelong PE did less well with the interventions, particularly behavioural or use of Premjact spray, than those with acquired PE.

In relation to treatment modalities and the acceptability of these interventions the following discourse accentuates the association of problem spaces within the context of PE.

Treatment

The main treatment options used in the clinical management of PE include:

- Anaesthetic creams
- Behavioural modification
- Lidocaine-based creams/sprays
- SSRIs/Atypcial Tricyclic antidepressants/MAOIs
- Constriction bands/desensitising bands.

The biomedical evidence base for treatment draws heavily on studies using SSRIs, and has called into question the long-term efficacy of behavioural modification. Whilst researchers have found that long-term delay with behavioural modification has not been sustained (refer to DeAmicus, 1985), long-term use of SSRIs has not been commonly used because of side effects with these medications. The proposed definition of lifelong PE is based upon evidence-based studies of men willing to volunteer to participate in clinical trials and utilise stopwatches to time ELT (or more accurately IELT since most studies are focussed on heterosexual men). No mention has been made of any cultural influences that may exist in either prevention of enrolment to a clinical study, or measurement of ELT in any of the treatments normally used in the clinical management of PE. This research has therefore offered new contexts of importance for understanding treatment selection.

Stopwatches as a means of stratification

Eight participants had severe PE, 11 moderate PE and 3 mild PE; the remaining participant's ELT was more than 120 seconds. The stopwatch timings were included in the research design to correspond with other (quantitative) research trials and to offer an objective measure of ejaculatory delay. The results of this research indicate that a) stopwatches were not always acceptable during sexual intercourse, and b) that participants were not compliant with recording ELT at each intercourse. What this indicates is that the use of a stopwatch in and of itself, can cause further distress in the relationship, but more importantly, use of a stopwatch does not confer an objective measure of ejaculatory latency. What it does provide is, at best, an estimation of the time between intromission and emission. Is this a significant factor in clinical management? Again, drawing on the results from this research, I would argue that it is not. What men were interested in was delaying for a *quantitatively* longer period of time, not a *qualitatively* longer period of time. In the research it was more important to men to have a clinically significant delay to ejaculation rather than a statistically significant delay. This draws into question the whole methodological imperative concerning the use of a stopwatch to time sexual activity. This leads on to a

conceptual analysis – why does the medical literature concern itself so much with stopwatch measurement of ELT? There is a three-way argument that is of itself concerned with governmentality. The biomedical literature views the use of the stopwatch as a means by which to standardise treatment; thus allowing comparison of methods/treatments/interventions, so that each can be evaluated. This would seem, from one perspective, simply a desire to generate enough knowledge about the subject to be able to help individuals with PE. Such is the modernist perspective of medical intervention; one that perceives power as positive and envisages knowledge and truth as objective. The clinician gazes *into* the dysfunctional body, compares the ELTs to a set of normal values, and seeks to intervene to delay ejaculation to another ELT; one that is more in keeping with the majority. This bioscientific view has become the dominant force in research into PE. Some psychologists are beginning to conform to this view; particularly when attempting to differentiate between lifelong PE and acquired PE, or what Rowland and Motofei, (2007) state as hard-wired and soft-wired factors in diagnosing PE.

What is of interest here is considering the *Why* and *What* questions. Why is ELT seen as this important end point? What resonance does this have with participants in this research? From a Foucauldian perspective there are three positions to view this concept; the first is to consider power, the second is panopticism and the third is the position of the participant.

Power: do not ask for whom the bell tolls, it tolls for thee

Foucault contends that 'power is everywhere' (Foucault, 1979a: 93), working at the 'capillary level' and reaching 'into the very grain of individuals' synaptic regime of power, a regime of its exercise *within* the social body, rather than *from above* it' (Foucault, 1980: 39).

Foucault links power to knowledge by use of the term *discipline*, which signifies both knowledge that is specific to certain domains, for example, medicine, and to the disciplining or control of the body. For Foucault, individuals are caught up and are actively engaged in constituting their

relative positions of power in grids of disciplinary power. Individuals' subjectivities are constituted through a myriad of discursive practices of disciplinary power that target particular individuals or collections of individuals.

Power can be seen as either positive or constraining, and governmentality is a form of power exerted on and through the social populace by institutions of social regulation and control, which in this case, is the medical clinic. Foucault views governmentality as being pervasive and situated within institutional discourses, but also allows for the possibility of resistance. Foucault emphasises the existence of micro-practices of power as being enacted between particular individuals in various institutional sites, and as embodying struggle and negotiation. Foucault suggests that it is only through analysis of these micro-sites that practices of power or governmentality might be identified.

Within clinician-patient communications, the positionings and repositionings of the participants within the clinical setting, and of the subsequent published reports of these clinical encounters, demonstrate a shifting nature of discursive practices within and through the language used. The clinical knowledge resides with the expert clinician, but this knowledge is transferred through discourses (whether narrative or written) to the subject, who then occupies the space or role of the premature ejaculator. Examples of various forms of clinician-based communications show clinical experts discursively positioned, and they position themselves as experts within the collective discourses and writings about clinical management of premature ejaculation. Patients, or more accurately patients willing to engage with research projects, position themselves as experts of the lived experience of their condition. Whilst such discourses are relevant for these patients, those unwilling (or unable for whatever reason) to engage with research projects, are positioned outside of the normalised discursive practices, making themselves a) an exotic other group, and b) a group judged against the artificially constructed norm of sexual practices and ejaculatory latency times. For those unwilling (or whose relationships do not allow) use of a stopwatch, they become positioned outside of these normal discursive practises. For these men, they continue to

experience PE, but do not have recourse to being labelled as such, and so cannot obtain any form of legitimised treatment. The key to the label is subjecting oneself to medical surveillance (the panoptic).

Panopticism

A key concept underlying Foucault's theory of regulatory control is that of surveillance through panopticism. Panopticism originates from architectural design, the panopticon, a building that rendered all inhabitants of an institution (usually a prison) visible, although in healthcare practice, this is linked to the 'Nightingale' style wards, where the nurse could gaze on all patients from the nurse's station but the patients would not know that they were being observed. Because of this constant (possible) observation, individuals have learned to regulate themselves and their bodies, rather than being regulated. Individual subjectivities are formed through social practices of self regulation of the body according to particular institutional discourses of knowledge (Keogh, 1996).

Panopticism is evidenced in the clinic by virtue of patients attending the medical clinic for treatment; to be observed by the clinician. The clinic then forms the boundary of the clinician's area of responsibility for regulation and control of bodies, both in time and in geographical space. This geographical space has become discursively produced as a moral space, and responsibility for the surveillance of patients is constituted and negotiated within such locations through clinical encounters and the subsequent clinical (published) papers about the syndrome/clinical problem.

It is only in the clinical space that legitimate discussions can be had between individuals; as participant S states:

> '*Bangladeshi women will never discuss sexual activity with a third party, and certainly not with a male clinician. Only men can do this, and only with other men*'.

Governmentality in clinical encounters

Clinician-patient encounters become the means by which premature ejaculation becomes known, at least to a wider audience than one's partner, and it is also where disciplinary knowledge is gained and deployed. These constructions of premature ejaculation are not neutral, but reflect regimes of truth within an officially sanctioned location (medical clinic). The discourses related to three dominant themes are presented here. An extract from each main theme illustrates how the individual is normalised by the disciplinary practice of biomedicine, and how patients collude, at some levels, with this normalisation until the suggested treatment interventions collide with their own expectation of normal sexual activity and acceptable treatment options. These latter tensions are illustrated within psychological and cultural discourses, which also highlight the contradictions and dichotomies in clinical practice.

This thesis speculated on the motivation for treatment by looking outside the geographical boundary of the clinic by asking participants about their partners' perceptions of the condition, and of the impact that the condition has on them. One of the treatments offered in the RCT was behavioural therapy, and although this was modified to exclude solitary and mutual masturbation, it positions the problem in another location (the home) where willing (or otherwise) participants have to practice the recommended treatments.

The panoptic of the clinic does not (and cannot) extend to the participants' private space (the bedroom) and therefore the participants themselves are expected to conform to expected norms, or in other words, follow the clinician's recommendations, which they then have to admit whether these instructions were completed or not.

The clinical gaze is as a result expected to extend beyond the clinic into an entirely hidden and private world of the participant's own construction of reality and normality of sexual activity, and thereby re-normalises this by reference to written texts that reproduce the disciplinary power/knowledge.

Commonly occurring features in clinical encounters such as these evidence Foucault's notion of governmentality, that is, the normalising and regulatory power of institutional discourses in relation to the positioning of docile bodies within time and space. It is the geographical space (the clinic) that are constituted as moral spaces, where sexual activity is cleansed and rationalised, whereas in the non-clinical setting sexual activity is irrational and deviant. The irrational and deviant is the subjective experience of sexual activity and it's meanings that are attributed by the participants. Clinicians have responsibility for themselves and each other as subjects and agents of disciplinary power in relation to the regulation of clinical practice.

In light of the aforementioned, some examples of printed (biomedical) journals that also evidence textual practices of governmentality are presented within the context of PE.

Governmentality of written texts

The following three texts are drawn from contemporary papers discussing the prevalence and causes of premature ejaculation. All main authors have extensively published discussions about PE and can be said to be opinion leaders in terms of biomedical discourses; these are Waldinger, Rowland and Motofei, and Riley. Each document includes text concerning the positioning in space of patients. Clinicians are positioned as being responsible for patient surveillance and regulation. Occupying the space as a reflective practitioner, it is possible to acknowledge the positions that clinician and patients occupy, both within clinical encounters and within research participation.

Text segment 1

> The perception of lifelong premature ejaculation (PE) has evolved from that of a relatively obscure complaint to one of a relatively common syndrome with a neurobiological component. During the last century, four historical periods, each about 30 years in duration, can be distinguished. In these periods PE was regarded according to the major prevailing viewpoint of mental disorders, that is from

> phenomenological, psychoanalytic, behavioural, and neurobiological points of view. Although influences of these different periods on the medical approach to PE are still present today, recent scientific evidence suggests that lifelong PE is related to an imbalance in central serotonin neurotransmission. A basic premise for further research remains an evidence-based definition of PE. Such an evidence-based definition is essential to ensure accurate and reproducible clinical outcomes (Waldinger, 2007: 762).

Within the first paragraph there is the explicit evolution of knowledge of PE from something poorly defined to something that has attained a scientific (and therefore more valued) term of syndrome and a scientific status of neurobiological component. The authority or position of the writer is assured by the very use of scientific discourse, and as such positions patients, and patients' knowledge or experience of PE, as less worthy (less scientific) and subsequently of less value within the understanding of PE to the individual. What this further exemplifies is that the clinical gaze passes from the clinic *into* the patients' home. Waldinger goes on to illustrate the advances of scientific knowledge, and thereby the disciplinary power, by referring to time, in this instance, the time that knowledge of PE has been accrued, and also how the ownership has passed from one discipline to another discipline, i.e. from psychology to medicine, as if this is a natural order of developmental knowledge. His final point is related to a definition of PE, which he later provides, because *an evidence-based definition is essential to ensure accurate and reproducible clinical outcomes* (Waldinger, 2007: 764), which is to reduce the individual knowledge of sex (and ejaculatory latency) from the personal to a state where men can be measured. This exemplifies governmentality of sex, where men whose ejaculatory latencies that fall outside the medical criteria for normal are brought back into line though pharmacological means.

Biomedical discourses seek to reduce illness to a definable set of clinical signs (Engel, 1977) and although PE has yet to be positioned as an illness, medical terminology has been used to explain the phenomena. The position

of PE at the present time is as a syndrome, with differential features based on time to ejaculate (measured using a chronometer). For PE, these clinical signs have been distilled into a definition that is based on a measure of time (IELT or ELT); acknowledges interpersonal distress in either or both partners (i.e. acknowledging the psychology of sexual dysfunction), and is not as a result of pharmacological disturbance (withdrawal of opiates or SSRIs, for example).

Recently, the elements of the definition offered by the American Psychological Association (DSM-IV) and also the International Classification of Diseases (ICD-10) have been adjusted to emphasise the element of time, with both Waldinger and Jannini offering stratification to the time taken to ejaculate, i.e. severe, moderate and mild PE. If the stratification related to time is linked to how men feel about PE, a logical assumption would be that those with severe PE would also have the most interpersonal distress, as evidenced by narratives using discourses that adequately reflect the devastation that they would be feeling. Results from the thematic analysis did not identify a sound relationship between ELT and the level of distress by the man or his partner. Furthermore, whilst it may be attractive to use a measure of time to establish the severity of PE, it isn't always possible; particularly where relationships are under strain, because using such an external means of measuring latency adds further criticism to sexual activity.

In medical trials, use of a chronometer is an established methodological requirement, but what is unclear is any artefact that use of a stopwatch brings to any sexual encounter. For example, participant J said that the use of the stopwatch initially increased tension in his sexual relationship. Furthermore, even though participants were asked to record each sexual encounter, only a few actually attended clinic with a written list of their ELTs, and most claimed to remember their stopwatch times, which calls into question the accuracy of stopwatch assessed ELT. Alternative forms of data gathering, for example using electronic diaries, have been found to be more accurate when compared to paper diaries (Stone, et al. 2003), but given the problems with discussing sexual activity with their partners and timing intercourse generally,

it is unclear whether using an electronic diary would have improved data collection. Most men who had successful treatment were able to *qualitatively* claim an improved delay in their ejaculation times, which they were either satisfied or extremely satisfied with. This further raises methodological questions. If the man with PE reports an improvement in his sexual life and greater satisfaction with sexual activity, what does it matter how long it is between ejaculation and emission?

Coupled with the definition of PE using a time criterion is that of distress, whether in the person or in the relationship. Again, no correlation was identified between differential feature of PE and degree of distress. The results of the research indicate that a) there are no material differences in the level of distress or ELT between lifelong and acquired premature ejaculators, that is, men with lifelong PE and acquired PE can be equally devastated, or equally not report any change in their lives, and b) that partners' perceptions of PE are important in what motivates men to seek help. Unfortunately, none of the men who reported that they were 'devastated' by PE and that their partners gave them 'non-verbal' or 'verbal' 'hassle', attended the clinic to either support their partners, or discuss what their role in any therapeutic intervention might be. These results challenge the assumption that a differential feature of lifelong/acquired PE is an important aspect in the group of participants, but reinforces the observation that partners are integral in defining PE and personalising management of the condition.

Six men had lifelong PE and 17 men had acquired PE. Most of these men had had PE for a number of years. Following discovery of the problem, it took >12 months for referral, and a further 2 months before being reviewed in the clinic. Conventional understanding of PE suggests that men with lifelong PE report higher degrees of relationship dysfunction and stress when compared to men with acquired PE. Notwithstanding, no discernible differences in discourses were found during the analysis between groups.

Certainly men with acquired PE over-represented the sample, perhaps indicating that men with acquired PE are keen for treatment. The data may

therefore be biased but this bias is precisely what the research question needed; only those most distressed by PE seek treatment (or volunteer for participation in research trials), therefore these motivated men are able to offer insights into the most distressed group. Certainly these results are not generalisable to a wider population, but that was never the purpose of the research. Information about those motivated to participate was needed to help understand some of the pressures and drivers for treatment.

Many men with PE were desperate for a quick-fix medical intervention. Twenty one men (62% of the sample) had cultural/religious objections to engaging in behavioural therapy that required masturbation, which is a consistent finding in men who are from Asian cultures (Gupta, 1994; 1998). Partners were usually absent from the clinical encounters, with a common narrative from men being "*I was sent in by my wife to get cured*". Interestingly, the discourses indicated less bother in those men who had lifelong PE, which suggest that perhaps their partners had become used to early ejaculation, although this may be due to relatively fewer number of lifelong premature ejaculators in the research. One further possible explanation to severity of PE is whether the relationship had borne children or not, but correlating the number and gender of the children did not reveal any relationship between these variables. Although the degree of bother did not seem to be related to the whether the couple were childless or not, there was a recurrent discourse about the importance of children, particularly boys, to be produced relatively early on in the marriage.

The degree of partner distress may be related to a generalised lack of intimacy. Narratives from participants and their partners (when possible) reported that sexual intercourse carries a great deal of importance because of the loss or lack of intimacy within the general relationship. This discourse was more prevalent in Bangladeshi (Sylhet) Muslim men when compared to other Bangladeshi men. It mirrors a breakdown in relationships in men who report ED for more than 6 months, which is that partners lose interest in sex. The data presented indicates that foreplay is relatively brief, or in some cases non existent, and consequently, techniques for pleasuring partners are either

unknown or absent. This finding is largely borne out by reference to the absence of sex education. Whilst UK sex education will not involve discussion of how to engage in foreplay, there are many avenues open to British men (for example, pre-marital sex, pornography, titillation, etc) that is haram for Bangladeshi Muslim men. This begs the question: How do men learn to be good lovers in the absence of a) education, or b) opportunities to experiment? Whilst experimentation may be possible within marriage for these men, sex takes on a greater meaning, in relation to expected norms.

According to Gupta (1999) Asian men, specifically South Asian (Indian, Pakistani and Bangladeshi) men, have a host of associated psychosomatic symptoms when presenting with sexual dysfunctions, for example, depression, sleeplessness, generalised weakness, and changes to semen quality. Fifty percent of participants in this research reported all over body pain and generalised weakness. Indeed the weakness discourse was used to explain why masturbation was an unacceptable form of therapy (masturbation makes you weak).

Semen is considered to be a vital substance for many cultures. For some men, they were concerned that their semen was weak, possibly as a result of premature ejaculation and/or masturbation. In the pre-trial investigation, many men reported that they would engage in behavioural therapy, but subsequently admitted that they were too ashamed to do so and that masturbating would make them worse. These men were at pains to describe PE in terms of medical causation and therefore treatment uptake was influenced by how they thought PE was caused. For example, a physical cause needed a physical (tablet) solution. SSRIs, particularly paroxetine, had already proven to be effective in delaying ejaculation (evidence drawn from the literature and clinical experience), and therefore many men wanted this as an option for curative treatment. Whilst SSRIs may provide a sustained delay in ejaculation after cessation, this tends to be in men with acquired rather than lifelong premature ejaculation (Arafa and Shamloul, 2006). In men with lifelong PE, once the medication has been stopped, ELT dwindles back to baseline levels.

Text segment 2

> Recent attempts to find effective pharmacological treatments for premature ejaculation (PE) have spurred significant interest in the causes of, consequences of, and existing therapies for this common male sexual dysfunction. The recurring tendency in science and medicine, however, to dichotomise causes of such problems into either biological or psychological is not only counterproductive, it is misguided. Ejaculatory response should be viewed as a system of integrated and inseparable hardwired and softwired central and peripheral responses, some being readily modifiable, others not. Such a view argues that treatment of PE aimed at multiple levels of functioning will be self-enhancing and ultimately more effective in producing therapeutic outcomes than strategies relying solely on either psychological or biological approaches (Rowland and Motofei, 2007:79).

Rowland and Motofei (2007) offer a counter argument to Waldinger's definition of PE, while in Waldinger's text extract he was referring to lifelong rather than acquired or psychogenic PE, the relative positioning of clinician and patient remain the same, as does the example of disciplinary governmentality. A similar position is adopted here albeit combining medicine/science with psychology since both offer disciplinary knowledge and power. No mention is made of the situation in which the premature ejaculator finds himself, nor of the cultural expectations that, as a member of any society, he is exposed to. The medical gaze in this text segment does not appear to extend beyond the clinic, but the expectation that the individual seeks appropriate knowledge from a group where the corpus of knowledge about PE has been distilled, remains. It is more difficult to see how surveillance is undertaken within this joint model of understanding of PE. What this indicates is that it is the individual responsible to self-surveillance, where he acknowledges his PE (however he defines it) and accesses appropriate (and approved) care to aid him in resolving his problem. In essence, the problem remains pathologised but not in such neurobiological terms that Waldinger uses.

Examining the data from a psychological perspective, motivations for seeking treatment were identified along with the impact that PE had on the individual. Discourses focused on concepts of masculinity, expectations of normal social behaviour and the power associated with semen.

Participants claimed that they sought treatment immediately, but this was not borne out by the number of years that they had had PE. Many narratives were apparently contradictory, which may be because participants were not sure what was being asked, and were keen to give the responses that they thought I wanted, rather than giving an accurate picture of their sexual history.

For many participants, they reported high degrees of stress related to their sex lives, and for some, these stresses affected all aspects of their lives. However, these stress levels seemed to be related to certain periods of time. PE became more stressful if there were no children produced, then less stressful afterwards. A period of tolerance then ensued for between 6 – 10 years. After this time, men were '*sent in*' to be treated. Partner's responses to PE ranged from verbalised annoyance to non-verbal annoyance, to no response at all. Very few partner's attended the clinic with their husbands, indicating that the degree of support was limited. These limits appear related to cultural mores (inability to discuss sexual activity with a third party) rather than simply not wishing to support their husbands.

One of the most interesting discourses centred on what normal ejaculatory latency was. Out of 23 qualitative responses, only 2 wanted to delay "*until she was satisfied*" (refer to table 5.12). Most constructed normal sexual activity by describing a timeframe, but no indication of time was provided, and no ranges offered to guide the responses during the interviews. Two men wanted very long ejaculation times, i.e. >21 minutes. No men indicated that they wanted to last until both were satisfied.

Text segment 3

> There is increasing interest in the management of premature ejaculation (PE), including the search for improved pharmacological

> approaches triggered by the potentially very large marketing opportunity. Just how large the market may be is difficult to predict. Estimates are based on epidemiological findings, but prevalence figures vary greatly depending on the operational definition of PE used in the questionnaires employed in their generation. Numerous definitions and diagnostic criteria have been used. Assessment of other dimensions such as feelings of ejaculatory control and satisfaction with sexual performance are more important. These subjective dimensions rely on the couple's sexual expectations, communication and other behavioural factors. The first step in the management of PE should involve obtaining a comprehensive sexual and relationship history (ideally from both partners), identifying and addressing these issues; not the prescription of ejaculation-delaying medication. This is especially important in view of the co-morbidity of PE with other sexual and relationship difficulties in men and their partners which could be aggravated by or negate the response to pharmacotherapy in terms of overall satisfactory outcome (Riley, 2007: 13).

This final text segment deals with two issues, the first is the pathologisation of sex, normalising sexual activity and ejaculatory latency, and the second issue is more cultured and textured, although makes assumptions that partners will discuss sexual activity with a third party, or that the relationship is intimate enough to engage with this form of communication. The assumption is based on an openness and a level of sophistication to sensitivity to articulate one's problem and to discuss sexual activity in a non-judgemental and open way. These assumptions are based on Westernised concepts of governmentality (permissible sex education at school; explicit knowledge of where to access help; articulation of the problem to elicit help from an approved source, etc.). There is no acknowledgement of cultural barriers to discussing sexual activity, particularly where English is not the first language of the client/patient and where local taboos prevent such discourses.

The above examples are not isolated examples of the stress laid upon a definition of PE and the need to pathologise sexual activity. From both

psychological and cultural narratives it would seem that there is little or no physical contact or intimacy outside of intercourse and so intercourse is the only time that affection/intimacy is shown. This may mean that the wife has a high demand for sexual activity, perhaps as much as every day, not because there is a high demand for sexual intercourse per se, but there is a demand for intimacy.

Sexual activity seemed to be instigated by the man and in some cases there was little or no foreplay related to sexual intercourse, indicting that sexual activity, at least for these men, had nothing to do with intimacy.

Sex education or informative discussions about the expectations of sexual activity were markedly missing in Bangladeshi men (and women). It appears that individuals are just expected to get on with the physical side of their relationships, and not be given any clues or help to deal with any problems that may arise. A key recommendation based on this research is some form of culturally acceptable sex education/forums that will assist these individuals in at least knowing where to access help and what words to use when doing this. There did appear to be some variation in narratives between British Bangladeshis, Bangladeshis and Sylheti Bangladeshis, with Sylheti Bangladeshis reporting the least amount of sex education.

The preceding sections are summaries of the narratives and themes identified in this research. The concept of governmentality; an analysis of the governmentality of PE from the disciplinary practices of medicine, the hospital clinic and religion/culture are considered now as it relates to compliance and resistance.

Compliance and resistance

The extent to which patients agree with the stratification of their ejaculatory latency times, or indeed, with the diagnosis of PE is impossible to know. Patient's who disagree with the clinical diagnosis or with the treatment options available, simply disappear from the clinic, or look to alternative sources of

information to explain their condition. This is a finding in the clinic, where participants often disappear for several years and then re-present to the clinic hoping for a different diagnosis or treatment. For the Bangladeshi men, pharmacological options are demanded more than behavioural interventions, particularly in the Sylheti men, where the separation between mind and body appears to be most apparent. These men were most resistant to using stopwatches to measure ejaculatory latency, or to attend appointments at agreed dates/times. For these latter men, governmentality is viewed within the biomedical paradigm of health and illness. For non-Sylheti men, there was an acknowledgement that anxiety had an impact on the experience of PE, but not the clinical management. These men agreed that pressure to perform created problems but the solution remained pharmacological. These findings are in contrast to the Westernised Bangladeshi men (or their partners) who were more willing to engage (and complete) behavioural therapy interventions.

From analysis of various types of communications (i.e. narratives from the research project and text extracts from selected publications), it seems reasonable to view clinics as agencies of regulation and control over sexual activity, at least, sexual activity that is seen to be outside the normal. Directions regarding the normal time to ejaculation are included in talk and published texts, aimed at articulating normality and, by extension, classifying those who fall outside of the normal. Recently attempts have been made to clarify the differential feature of PE (lifelong or acquired) but as the results from this research indicate, the definition of lifelong PE could have been applied to all of the participants in the trial. Yet it would seem difficult to know who would not qualify for such a position because of the language used to position men with PE. Clinicians and patients collude with this positioning; particularly within biomedical discourses, perhaps because of sexual mores and taboos (the finding that intimacy is not shown outside of the bedroom, and sex education is absent from education at home or in school). Ultimately, the Bangladeshi Muslim participants colluded with the biomedical construction of ejaculatory latency, by exposing themselves to the panoptic gaze, which is extended from the clinic into the patients' homes. Participants subsequently learnt about the panopticon which asks them to practice self-governance, i.e.

to time their ejaculatory latencies, to continue to seek biomedical help, and to seek to delay their ejaculatory times to an established normal range. In this way, the clinician, the patient and indeed society, become subjects and agents within contemporary disciplinary society.

Discernment of new knowledge

Data on the meanings that Bangladeshi Muslim men have not, as far as can be established, been explored before. Bangladeshi men are very reluctant to engage in research studies. Subsequently, there is no acknowledgement of the needs of this cultural group. Whilst these results cannot be extrapolated to all Bangladeshi Muslim men, the results will have profound impact into local clinical management. The results of the research have already been published (refer to Steggall, et al. 2008) and presented at local educational meetings. The practice in the local clinic has changed, based on these findings. Bangladeshi men are now offered pharmacological intervention followed by behavioural therapy. This is because of the degree of anxiety in the relationships and the reluctance in engaging with behavioural therapies as a first-line therapy. For those men who undergo joint therapy (i.e. pharmacology followed at 6 weeks by behavioural therapy) they report improvements in both subjective assessment of their relationships and a delay in ELT. Whether this delay is sustainable has yet to be determined.

Problems (recruitment and compliance)

Recruitment for the research was not as high as expected. This was because of local changes in commissioning of services and concerns by other service providers facing withdrawal of funding for sexual dysfunction services. Use of a stopwatch caused several prospective participants to disengage from the research (or simply not attend further appointments). In general, when the project was explained to participants, they were reluctant to enrol on to the research, preferring to simply take a tablet to cope with the problem. These men were adamant that the solution was pharmacological and that no practice (masturbation) or reformulation of the constructs of their sexual lives, were

necessary. These same men were resistant to behavioural therapies or even referral to behavioural therapies. Although the research was approved by the local Imams and the President of the Shar'ia Council of Great Britain, participants (or potential participants) were not concerned with this; again believing that the sole cause of PE was something physical. Generally compliance with research protocols was poor, with most patients missing scheduled appointments or arriving at incorrect times (despite arranging follow up appointment times/date with the participant directly and providing a contact number in case of need). Most patients were passive recipients of care rather than activity engaged in finding a solution to the problem. This is in marked contrast to men who have erectile dysfunction, who have often sought independent (internet) information prior to consultations and engage in discussions related to treatment.

Limitations of the research

Participants knew the aims of the research and were consented to provide both quantitative and qualitative information. However, given the paucity of services available to men with PE, their options for treatment were so limited that they may have felt that their options regarding participation were limited. Attempting to engage men from marginalised groups into clinically relevant research is important to because it helps to explain why certain behaviours are permissible and others' are not. At no time was data included that men were not aware would be used to contextualise and bring to life the scientific data. The research was conducted using recommended research guidelines. Ethical approval was granted for both aspects of the research.

Very few of the narratives were from the men's partners; predominantly because partners did not attend the clinic, and often because they did not see any need for them to do so. On the rare occasions that Bangladeshi wives attended, their behaviour indicated acute discomfort at discussing anything associated with sexual activity. Whilst this may have been related to my gender, a female clinician familiar with the research was always available. Women did not want to discuss sexual activity with them either. What is

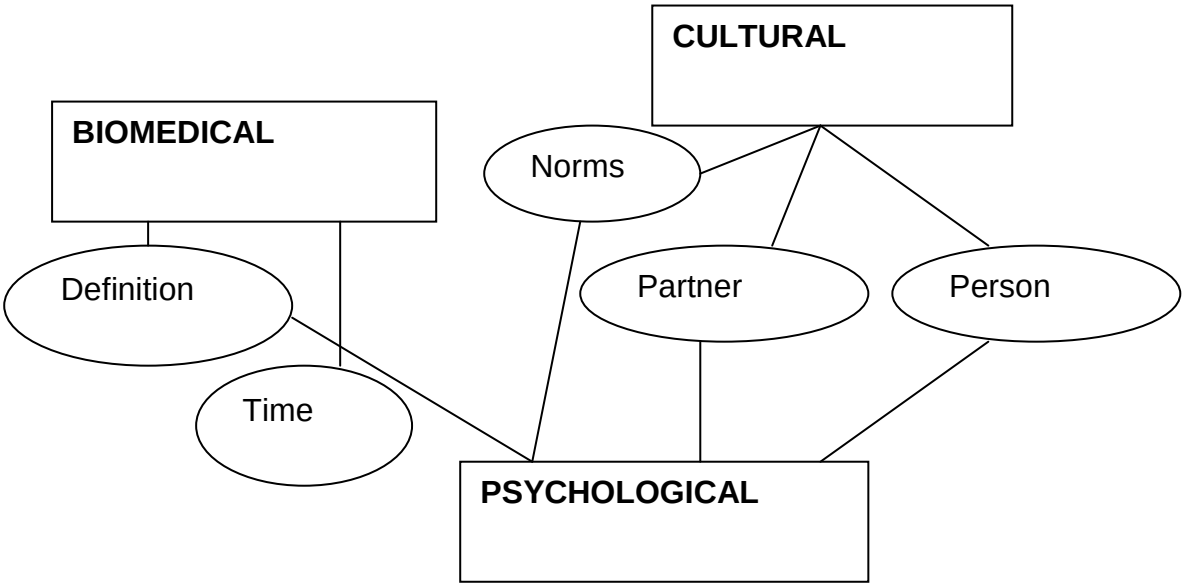
needed is research exploring women's attitudes to PE, identification of norms and expectations of marriage, and to establish a) what information is provided to women before marriage, b) where women go to get marriage guidance, and c) why taboos exist concerning discussions of sexual activity when the Muslim religion promotes the Family as an ideal unit for support.

It is evident from the design of the research that Muslim men, who over-represent the local population in respect of distress of PE, do not comply with treatment regimes; particularly when compared with other cultural groups. There was anxiety over the use of the words 'trial' and 'research' for some men, and they were re-counselled that participation in the research was completely voluntary. Bangladeshi Muslim men were also very reluctant to engage in discussions of how to help themselves with PE. They wanted the clinician to make all the decisions; agreeing with them in clinic, then, if they disagreed, they would simply fail to attend follow up appointments until re-referred by their GP. On return, they also hoped to see a different clinician and to be passive recipients of care again. This calls in to question the current inclusive model of care, specifically patients-as-partners. Indeed, in examining the cultural discourses it became apparent that the home culture for decision making influenced how men expected clinical encounters to be. For some patients, options are counter-productive. An example is giving patients choices is interpreted as the clinician not knowing what they are doing. This is a key observation, and perhaps helps to explain patient's behaviours.

Summary

This chapter has discussed how Governmentality can be used to explore aspects of PE from diverse perspectives. Figure 6.1 shows the complexity of PE and the interrelationship between physiology, psychology and culture, which is of critical importance in the clinical management of PE.

Figure 6.1 Final thematic map



Chapter 7

Conclusion

PE is a common and complex problem that is constructed and understood from different perspectives. Biomedical, psychological and cultural factors influence treatment-seeking behaviours and ability to engage in certain treatments. The condition is not culture-free, as contended by Giuliano, et al. (2008) but deeply embedded in normalised sexual behaviours. Bangladeshi Muslim men find themselves experiencing considerable pressures to perform during marriage, in the absence of sex education or pre-marital sexual activity. Contemporary knowledge from Bangladeshi Muslim men concerning PE is missing from published literature. This research has explicated the cultural meanings of PE in Bangladeshi Muslim men, and has explored the medicalisation of the condition.

Research question and aims:

The primary research question driving this research was: What are the factors that form Bangladeshi Muslim men's knowledge(s) or PE? The associated aims were:

- What are the norms of sexual activity in Bangladeshi Muslim men with PE?
- What are the barriers to discussing sexual activity and engaging in treatments for PE?
- How do Bangladeshi Muslim men construct knowledge of PE?

Major findings and new knowledge

The main findings of this research are that men are positioned as deviant based on data that is drawn from men willing to engage in Internet-based

studies or in clinical trials. Thus, PE has become known and understood through knowledge of motivated men. There is no mention of the impact of culture in understanding the components of PE. Using thematic analysis, Bangladeshi Muslim men understand PE from three perspectives, biomedical, psychological and cultural.

The biomedical theme explains PE in terms of time and not in terms of mutual sexual activity or enjoyment. Men commonly delay seeking treatment for 6-10 years. During this time, they have met social norms by production of children. Additionally, they have also noticed a change in PERT, which is a major motivator (after pressure from their partner) to seek treatment. Frequency of sexual activity dwindled and exacerbated short ELTs by concomitant pressure to perform. None of the participants wanted to have an ELT that allowed mutual enjoyment of sexual activity; all understood successful sexual activity as a longer ELT (median was 6-10 minutes). Few participants found using a chronometer acceptable during intercourse, and some were unable to use one due to pressure from their partner. Causation of PE was usually linked to physical changes and only men raised in the UK acknowledged that pressure to perform *might* contribute to a shortened ELT.

The psychological theme revealed the location of power within the relationships; it was predominantly in the man's partner. Common discourses were that the man's partner was either non-verbally or verbally aggressive towards him, and some indeed were physically aggressive. Some of the unsubtle pressures brought to bear were threats to leave and take the children back to the home country unless the problem was resolved. Partners refused to acknowledge any role in treatment or support; the locus of the problem was entirely in the man and the cure was his alone. The consequences of PE affected all aspects of the man's life. Men believed that masturbation caused PE and hence were reluctant to engage in any form of behavioural intervention that involved non-penetrative activity.

From a cultural perspective (the cultural theme) there was no sex education or discussion of expected norms before or after marriage. All participants had

arranged marriages and all articulate the pressures to perform immediately after marriage. This is a critical finding. Absence of knowledge about normal sexual variation and activity contributes to the negative experiences of these men and of the explanation of PE in physical terms. Separation of mind from body allowed locus of control to pass from the man to the clinician. It became the clinician's responsibility to cure and the participant's responsibility to be the passive recipient of care. This also explains the absence of female partners from the clinic. Bangladeshi women are unable to discuss sexual activity anywhere except in their bedroom and then only with their husband. This finding, however, is only from the narratives of the men, and thus reinforces the need for research into women's understanding of sexual norms as well as feelings about PE. The final critical finding from this research is the absence of intimacy outside of sexual activity, resulting in increased performance anxiety. Bangladeshi Muslim men should not be considered an exotic other group and be marginalised in the literature which informs clinical practice. I have attempted to redress this missing data in the literature, and recommended a series of future directions to explore.

Recommendations for Research

- Multi-centre research including other Muslim participants, exploring similarities and differences between different groups of Muslims
- Bangladeshi women's views of PE and where the locus of control in respect of treatment lies from their perspective
- Interviews with Imams/Community leaders on the constructions of normal sexual activities and identities

Recommendations for Education

- Raising awareness of the PE in the local Bangladeshi community
- Education of health guides to promote knowledge of PE (where to seek help and to dispel myths regarding sexual function)
- Disseminating the findings of the research to clinical colleagues and other sexual healthcare providers

Recommendations for Practice

- Behavioural therapy offered as an adjunct to pharmacological treatment for PE
- Longer appointments for Bangladeshi Muslim men to facilitate constructions of sexual behaviour

Summary

Cultural sensitivity is critical to understanding the meanings of PE in Bangladeshi Muslim men, particularly where clinicians are not from this cultural group. This research and thesis has explicated cultural meanings of PE by using thematic analysis. The philosophy of Foucault facilitated an exploration of power relationships (both personal and from disciplinary practices) through the concept of governmentality. It is hoped that this research will further the goals of better understanding of Bangladeshi Muslim men and provide them with the level of professional attention and understanding that they need and deserve.

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Appendices

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Publication and presentations

Publications

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Presentations

Steggall, M. J., Pryce, A. and Fowler, C. G. (2009) Loose nerves and weak blood: culture(s), Time and Governmentality in the biomedical treatment of Premature Ejaculation in Bangladeshi Muslim men. *Transcultural Nursing Conference, City University, London/Metropolia University, Helsinki, Finland* (video conference) February 2009

Steggall, M. J. (2007) Sequencing of Treatment Modalities For Clinical Management Of Premature Ejaculation: Results. *Invited lecture to St. Mary's GUM education forum. October 2007*

Steggall, M. J., Pryce, A and Fowler, C. G. (2007) Sequencing Of Treatment Modalities For Clinical Management Of Premature Ejaculation: Early Results. *18th World Congress of WAS, the 1st World Congress of Sexual Health, Australia, April 2007*

Steggall, M. J., Pryce, A and Fowler, C. G. (2007) "Loose Nerves, Weak Blood And Cold Climates" - Cultural Meanings And Explanations Of Premature Ejaculation Among S. Asian Men In East London. *18th World Congress of WAS, the 1st World Congress of Sexual Health, Australia, April 2007*

Steggall, M. J. (2006) Premature ejaculation: clinical management. Invited seminar, *Healthcare Research Unit, Institute of Health Sciences, City University, St. Bartholomew School of Nursing and Midwifery.*

Steggall, M. J. (March, 2006). Clinical management of premature ejaculation in ethnic minority groups. *Invited lecture at the Royal Society of Medicine. London*

Steggall, M.J., Pryce, A. and Fowler, C.G. (January 2005) Medical Ambivalence, Cultural Taboos and the Social Construction of Masturbation. *(Seminar) University Research Half-Day Event: Gender and Sexualities, City University, London.*

Steggall, M. J. and Pryce, A. (November, 2004) Rapid ejaculation: experiences of an East London Clinic. *Genito-Urinary Medicine, St. Mary's Hospital, London, GB.*

Steggall, M.J., Pryce, A. and Fowler, C.G. (October 2004) Rapid Ejaculation: An exploration of the biomedical, social and cultural constructions of therapy. *(Seminar) Healthcare Research Unit, Institute of Health Sciences, City University, St. Bartholomew School of Nursing and Midwifery.*

Steggall, M. J., Pryce, A. and Fowler, C. G. (June, 2004) Rapid ejaculation in Bengali Muslim Men Attending the Erectile Dysfunction Clinic In East London: the pitfalls of behavioural therapy. (Poster presentation - Proceedings Manual Published Abstract) *30th Annual Meeting International Academy of Sex Research, Helsinki, Finland,*

Steggall, M. J., Pryce, A. and Fowler, C. G. (May, 2004) Rapid ejaculation: experiences in an East London Clinic. (Invited Seminar presentation - Proceedings Manual Published Abstract) *7th European Federation of Sexology Congress Brighton, GB*

Steggall, M. J. and Pryce, A. (September, 2003) Medical ambivalence, cultural taboos and the social construction of masturbation. (Seminar presentation - Proceedings Manual Published Abstract) *6th European Sociological Association, Murcia Spain*

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