Premature ejaculation: defining sex in the absence of context

Keywords

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Abstract

Medical and psychiatric literature defines premature, early or rapid ejaculation from diverse perspectives and provides explanations and treatment options that reflect their historical development. Medical discourse focuses on premature ejaculation as a neuro-biological phenomenon with a growing 'evidence' base emerging for both defining the condition and treating it with selective serotonin re-uptake inhibitors (SSRIs).

Current definitions of premature ejaculation however are difficult to deploy clinically; 'marked interpersonal distress' is a subjective measure and not all men are able (or willing) to time their sexual activity with a stopwatch. The addition of a defined measure of intravaginal ejaculatory latency time (IELT) is, perhaps, useful for research, but less so for the individual men with premature ejaculation. Psychiatric literature considers the diagnosis and management of premature ejaculation from a behavioural perspective, where the man learnt 'hurriedly' and therefore got into a pattern of hurried sexual activity, although there is no compelling data (or evidence) that adoption of behavioural therapies are successful in providing a 'cure' for the problem.

Both medical and psychological perspectives appear based on certain assumptions, i.e. that of the construction of 'normal' sexual activity and function. Neither medical rationalities nor psychological perspectives consider the *person* who is the premature ejaculator, and both generally fail to consider his social contexts and cultural meanings or the anxieties of managing gender-determined role performances. Similarly, the 'irrationalities' of erotic desire, intimacy and embodiment remain largely marginal or invisible elements in the pursuit of 'evidence'.

Whilst there is little sociological literature on the topic, premature ejaculation provides an example, *par excellence*, of an aspect of human experience that demonstrates the paradigmatic tensions between medical positivism and the cultural constructions of experience. This paper seeks to discuss premature ejaculation from another perspective, problematising the complexities of sometimes contradictory, social, sexual and gendered identities, and reflecting on a number of key areas that seem absent from the clinical literature on premature ejaculation.

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Introduction

Recent reports have sought to define premature ejaculation (PE) in terms of intravaginal ejaculatory latency time (IELT) and qualify the severity of the condition from 'none' to 'severe' in psychological terms [1]. The definition has been based on well-constructed epidemiological [2,3] evidence-based principles in a group of men who have admitted that they have PE and who have agreed to use a stopwatch to measure their IELT.

For a man to seek help that requires confession of PE, and then measure this with a stopwatch during sexual intercourse would seem unusual, suggesting that he must be anxious about his performance, or his partner unsatisfied with their sexual activity, but assessment of anxiety levels is not included in published reports.

Waldinger [1] qualifies the 'disease' of PE using a medicalised standard of disease definition for lifelong PE, based on clinical research that indicates that some men ejaculate in less than 1 minute.

This raises 4 key questions about the construction of the disease and the deployment of a measure of time to somehow 'qualify' the condition. The key questions are:

1. How does measuring IELT stratify sexual experience?
2. Are the subjects who have agreed to participate in research 'normal' or are they a particularly anxious set of men?
3. To what extent does environment play its role in the complex causes of premature ejaculation?
4. What are acceptable expectations of normal sexual activity?

This paper seeks to discuss these key questions and assumptions that underpin the qualification of PE, by examining the 'evidence' on which they have been constructed. PE is primarily determined in neurophysiological terms, describing a biological, sexual event. However in so doing, the diagnostic process marginalises complex networks of cultural meaning as well as the individual man's (and his partners') embodied and symbolic experience in the context of desire, intimacy and the performance of erotic interaction. Whilst of course, the person's actual experience of a phenomenon is unknown and essentially unknowable by others, it seems to us that a more effective deconstruction of PE must occur if we are to gain a more textured and sensitive appreciation of both the performativity of sex generally, and the implications of erotic dysfunction represented by premature ejaculation in particular. The aim of this paper is therefore to examine, with a more sociologically informed gaze the discourses related to PE and sexuality, and to reflect on the principles of evidence-based medicine, which may not be wholly appropriate for the management of this condition.

Prevalence

The true prevalence of PE remains unknown, but has been variously cited as, highly prevalent [4] and affecting 21% [5], 22–38% [6], 1%–75% [7] and 75% [8] of men.

These prevalence rates rely on three assumptions; firstly is that of an accurate measure of IELT, secondly, the man's veracity in reporting their IELT, and thirdly, the sample of men who are willing to participate in clinical studies, i.e. not all men who ejaculate early will seek treatment, therefore those who do may misrepresent the 'true' prevalence.

Each of these assumptions tends to presume a universality of both meaning and experience in the potential of ejaculation to have an objective marker of 'failure' or 'success'. In other words, the assumption privileges PE as a purely neurobiological dysfunction rather than ejaculation as an event that carries a massive cultural and symbolic load, where semen is invested not only as evidence of masculinity and erotic climax, but is also powerful, magical and sometimes dangerous. The current definitions of PE however, are located within discourses of pathology (psychological and organic) that require problematisation.

Diagnosis of premature ejaculation

Currently operational definitions of PE are drawn from the American Psychiatric Association [9], which uses three criterion to 'diagnose' the condition; that it is a persistent problem with minimal sexual stimulation, before or shortly after penetration, that the condition causes marked distress and that it is not caused by, for example, withdrawal of opiates. Lue et al. [10] further qualify the definition as brief ejaculatory latency, loss of control and psychological distress.

Waldinger [3] proposes that lifelong PE be defined as a 'neurobiology dysfunction with an unacceptable increase of risk to develop sexual and psychological problems'.

Additional features (in terms of clinical management) are whether the PE is lifelong or acquired and whether it is generalised or situational. The main difference between the two definitions appears to be the qualification of ejaculatory latency. Extensive research by Waldinger [1,11,12] has led to the contention that a stopwatch assessed IELT of less than 1 minute after vaginal intromission, should be used to qualify the condition.

Subjective/objective measurement

The addition of a stopwatch as a measure of 'success' or 'failure' reflects the intrinsic preoccupation of Western societies; that of time, in this case time being a measure of success. The definitions are functional rather than grounded in the context or meaning of the sexual encounter, and thereby represent the increasing penetration of reductive disciplinary practices into the understanding of complex individual, interpersonal and social experiences. For some people, sexual activity is seen as something akin to a religious experience [13], whilst for others it is for procreation and/or pleasure, but it is *always* a social practice and therefore laden with particular and contextualised meaning.

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. Simon and Gagnon [14] originated the notion that people use 'scripts' which are 'a metaphor for conceptualising the production of behaviour in social life'. In other words, such scripts provide the working basis for the performance of the person's gendered and sexual role, consistent with the demands and expectations of identity and desire within a particular culture. Drawing, in part, 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

In addition, these domains can extend to the biological or physiological dimensions of sex such as (unwanted) pregnancy, infection or indeed, 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 person (and couple) is therefore different and specific for that moment [15].

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' (1979:57ff), which he identifies as the *Ars 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'

The measurement of IELT therefore 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'' [33], with its concomitant assumptions, i.e. 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' [16] which becomes a form of social and cultural iatrogenesis [18].

The current construction of the scientific approach to premature ejaculation can be illustrated by its antonym, culture-bound syndromes.

Culture-bound syndromes

Historically semen anxiety loss, which includes PE, has been referred to as a culture-bound syndrome, a term used to describe the uniqueness of some syndromes in specific cultures. Dhat [17] (semen-loss anxiety) is a syndrome that partly provides a societal or cultural understanding of the importance of semen. Atharva-ved, one of the ancient Indian religious texts mentions that a hundred drops of blood are required to make one drop of

semen, so semen loss, whether through involuntary nocturnal emission, masturbation or PE during intercourse, can be seen as loss of strength [19]. Dhat syndrome has been considered to be an exotic 'neurosis of the Orient', although this definition is erroneous because all definitions are bound within their own cultural construct [20].

Culture-bound syndromes are at best vague but have been defined by Littlewood and Lispedge [21] as 'dramatic reactions specific to a particular community'. Hughes [22] proposed that these 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 [20].

In the case of Westernised-defined time-related PE, we have a subset of men who are unique in that they seek help and distinctive in that they measure their IELT using a stopwatch and find it to be less that 1 minute, making them 'outside' the mainstream population. An operational definition of IELT of less that 1 minute or 1.5 minutes effectively creates a disease process *in absentia* of the context of the sexual relationship.

Stratifying PE into none, mild, moderate or severe [1], further reinforces this notion of 'otherness' that is important in understanding culture-bound syndromes. But in this case it is not the person with the disease but the disease creating the person. An arbitrary measure of time does not reflect the complexity of sexuality, the pressure to perform at any given moment, or the subjective meaning of the sexual experience.

This is not to argue against IELT as *a* way of measuring PE, but rather to suggest that it can be one of several ways in which the experience of PE can be measured, in the same way that self-reported PE is also important. Pathologies that use defined criteria should have clear causes; PE has yet to have a clear cause, therefore codifying PE as a disease is deeply reductive.

Another concern with defining PE in less than 1 minute, is those men who self-report PE even though their IELT may be greater than 5 minutes. Although evidence-based medicine seeks to generate generalisable evidence, sexual intercourse is not something that can be measured against a 'standard'; the 'standard' is grounded in context and culture, and therefore, the subjective experience and definition from the patient should have equal weight when diagnosing PE. Applying the disease criteria proposed by Waldinger [1] would potentially exclude a subset of the population who would otherwise meet the criteria for diagnosis.

Clinical management of PE further presents the practitioner with two problems. The first is whether to accept the patient's definition, and second is whether to use a pharmacological intervention that, essentially, the participant will need to use for the remainder of his sexual life.

Treatment options

A review of the literature indicates a change in focus in the management of PE from a behavioural model, initially advocated by the Kinsey Institute and Masters and Johnson [23], to the finding that the side effects of selective serotonin re-uptake inhibitors (SSRIs) delay ejaculation in depressed men, and therefore may prove to be a treatment option in non-depressed men with rapid ejaculation [24,25,26]. Other (less investigated) methods for treatment include anaesthetic-based creams [27], desensitising rings [28] and constriction bands.

Recent evidence suggests that medication, principally SSRIs [10] and/or clomipramine [29] (a tricyclic antidepressant), could be used as first-line therapy superseding, for at least some practitioners, the strategy of behavioural therapy. Behavioural approaches that include sensate focus, stop/start and squeeze techniques (which involve masturbation), have not been 'proven' by the tenets of evidence-based medicine.

The use of SSRIs may reflect the change in emphasis in delivery of care and the embracement of evidence-based care/research, but there appears to be a conflict emerging between the disciplines of medicine, and the recommendation (by some) of long-term use of SSRIs, and psychiatry/psychology, with the continued use the various permutations of behavioural therapy, presenting clinical practitioners with two fundamental, interwoven problems central to the treatment options.

The first is primarily clinical management; should patients be exposed to the potential

side effects of unlicensed medication, or the traditional (and of questionable effectiveness) behavioural therapies; or should a combination of these approaches be used? The second is grounded in the cultural constructions of both PE and its treatments. Sexual activity is not undertaken without social meaning, either to the individual person, couple or the wider social group.

The selection of the treatment will depend to some extent on the clinician's own socio-cultural experience, philosophical perspective, exposure to the condition, and experience with the treatment options, but also the health beliefs and expectations of sexual activity from the 'patient' (Figure 1).

Some researchers [7] currently indicate that common psychosexual traits exist among men with PE, but psychological studies do not yield evidence of a common personality profile. Masters and Johnson [23] suggested that early sexual experiences were important in the shaping of future ejaculatory habits. Because of initial nervousness and haste, unsatisfactory early sexual experiences would 'programme' or 'script' a pattern of learned PE later on (a form of negative conditioning). Other authors cite inappropriate locations, e.g. back of the car, with the attendant fear of discovery, as the catalyst for creating PE. It is however important to point out that most researchers are operating within a Western worldview and a predominantly behavioural frame.

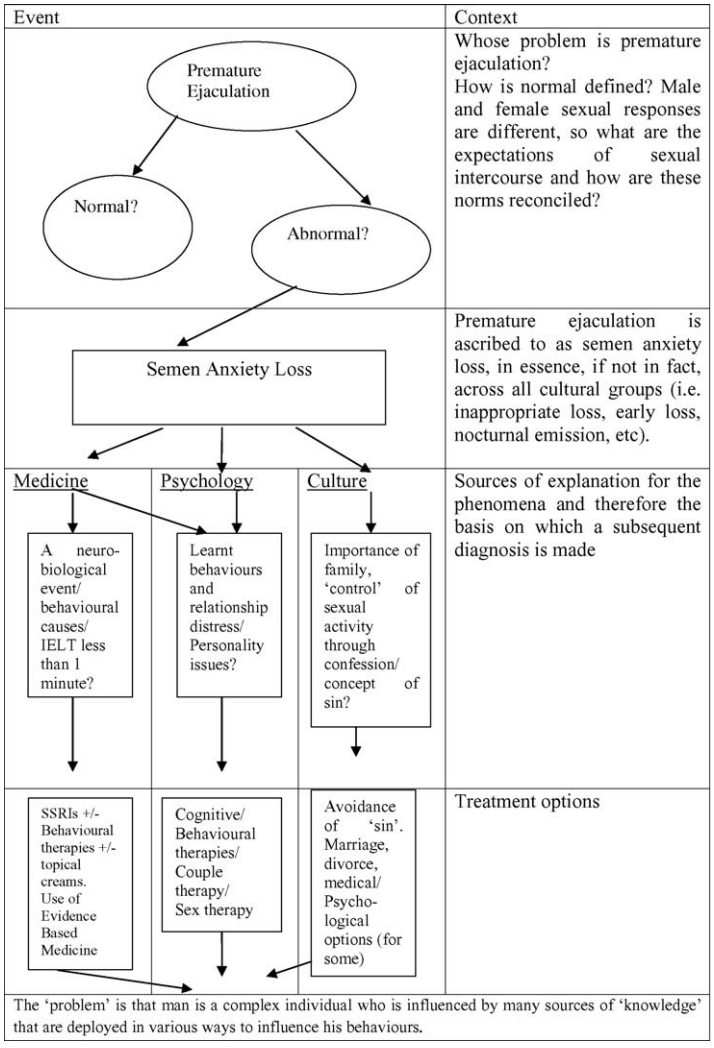

Figure 1 The premature ejaculator and the competing ideologies for explaining his 'condition'.

High levels of anxiety have been considered to be a causal factor, where distraction during intercourse occurs with resultant diminishing of awareness of the man's own responses. This inability to focus on their own response suggests a failure to recognise internal cues that signal the point of ejaculatory inevitability, and therefore to early ejaculation. This would further reinforce the behavioural nature of sexual activity rather than a neuro-biological abnormality and 'genetic' predisposition to ejaculate quickly.

In addition to physical causes, the patient's psychological state needs evaluation to determine the degree to which it is influencing ejaculatory patterns. Metz and Pryor [7] contend that PE is common in men with psychological disorders, psychological distress and in those with psychosexual skills deficit, making it more resistant to treatment than distress caused by psychosocial factors. However PE may be transitory, lasting as long as the events which influence the man (which could last a considerable length of time) and become lifelong-acquired as a result of learned behaviour during that period, in effect, performance anxiety exacerbates ejaculatory dysfunction and potentiates the condition [8].

This may be of critical importance when considering how the defining characteristics of 'normal' sexual responses are socially constructed, and the development of persistent premature (lifelong) ejaculation because each sexual encounter that has been interpreted as a 'failure' will increase pressure for the next encounter, thus developing a spiral of failure that will affect performance. This is particularly intriguing because not all men have the opportunity of observing how other men perform 'normal' sexual activities. Similarly, assuming

the absence for most men, of sustained same sex encounters that would provide a 'benchmark' of duration, it can be assumed that like many other elements of social knowledge, expectations of erotic performativity are heavily dependent on cultural scripting.

Hegemonic masculinities across cultures suggest that sexual 'failure' is a risk and its disclosure is profoundly shameful and discrediting. The burden of this secret may sometimes not be shared even with the partner, and if it is admitted at all, the confession should be bound by some form of confidentiality. In cultures where open discussion of sexual practices remains taboo, there might be little social or interpersonal 'evidence' against which a man might gauge expectations or measure his sexual performance.

In increasingly globalised societies where sexual discourses pervade cultural production, such as the media, expectations of 'normal' sexual practices may distort individual and social constructions of sexual practices, leading to new or increased anxieties when there is dissonance between the assumptions of sexual performance when compared with the person's lived experience.

In summary, it is unknown what normal ejaculatory latency time is, or what causes the condition. It remains a matter of contention as to whether the man or his partner is actually the 'owner' of the problem. Despite these uncertainties treatment options have been developed over time, often according to the dominant philosophical perspective of the day, but these philosophies are grounded in history, and these histories themselves reflect a more potent purpose. The theory and practice of sex and sexuality is historically enmeshed in complex relationships of one form or another, and as Foucault [30] conceptualised it, sex:

> . . .appears rather as an especially dense transfer point for relations of power: between men and women, young people and old people, parents and offspring, teachers and students, priests and laity, an administration and a population.

Certainly, this renders sex a most powerful and pervasive element in human activities. Where power is critical in relations such as those between clinical practitioners and patients, and where sexuality is both the clinical subject and a potential interactional danger, the instrumentality of sexuality produces new combinations of risk. Foucault [27] argued that power operated at the 'capillary', or individual, level and that it:

> reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives.

It can be argued that the performance of sexual identities, erotic practices and interactions echoes this, and provides the basis for deeply engrained and taken for granted assumptions of what is 'normal' or 'abnormal', 'natural' or 'un-natural'. This process recruits people into the monitoring of their behaviour and the surveillance of their practices.

Whose problem is premature ejaculation?

An example of the problematisation of PE can be exemplified by an answer to an online question taken from the Muslim web site www.islam-qa.com [31]:

> '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.'

The extent to which this comment reflects an Islamic perspective on sexual dysfunctions is debateable. However, what is clear is that concern over semen anxiety and therefore PE is grounded in individual experience, and the relationship with the partner. Therefore evidence-based approaches to management may not provide the 'cure' that the couple are seeking.

Operating under these conditions of psychological distress, it would be considered 'normal' to ejaculate quickly. The stressor is the partner, their expectations of sexual activity

and for some the social pressure to produce children (which 'complete' the family). In addition, children have economic power – a man with many children would be able to arrange marriages that can extend a business empire, or make 'strategic' marriages. The concept therefore of PE as a neurobiological event is questioned because there is quite clearly an external social pressure for 'normal' gendered performance.

Discussion

To call something premature suggests that there is at least a 'normal' or benchmark by which 'abnormal' can be measured. The construction of normality (by assumption since there is a definition of abnormality) has been based on men willing to report, however accurately, their IELT using a stopwatch. It is not clear whether the use of the stopwatch itself assists in delaying ejaculation as a distraction therapy.

By the nature of the questions that are used to define PE, there is a determination of how knowledge or truth about PE is generated. Is PE best understood in terms of aberrant neuroconduction and physiology, as Waldinger [1] indicates, or normative expectations of age, economics and politics of the family? Furthermore there is a stratification of abnormality that exhibits its own set of behaviours, expressions and use of language. The premature ejaculator therefore becomes a person, an entity that is examined against a set of scripts but which, essentially, has no definition.

Central themes to the question of PE, which have only partly been discussed in the literature, are how is PE experienced, named, measured, treated, and drawn into science, society, history and religion? How do these practices and experiences, differ over time, space and culture?

Premature ejaculation has been defined, providing a time and a set of experiences that assist in 'diagnosis' however, these observations, by definition, have only been undertaken on those willing to 'expose' themselves to 'scientific' scrutiny. What this leaves is an uncertain definition and an even more uncertain context for the man with PE.

Sex therapy, in various forms, is in danger of becoming rejected as a therapy because of the paucity of evidence-based studies using these methods. The evidence for the effectiveness of SSRI and other pharmacological therapies are compelling, but the literature does not concern itself with subjective experiences, and the new diagnostic criteria proposed by Waldinger [1] reduces sexual activity to a time-measured, goal-orientated physical event. A more sociological reading is that such an approach locates power at the heart of the medicalising science of sex. Foucault [32] argues sexuality is:

> not the most intractable element in power relations, but rather one of those endowed with the greatest instrumentality: useful for the greatest number of manoeuvres and capable of serving as a point of support, as a lynchpin, for the most varied strategies.

This great surface network of power relations is the social world of everyday life where bodies interact physically and symbolically. Each person is potentially the object of desire but also the subject of propriety laws, taboos, forms of cultural and disciplinary knowledge (such as medicine and psychiatry), as well as regulated through a moral order. Few other social and individual processes and experiences attract more powerful symbolic and physical meanings than ejaculation, and therefore it is unsurprising that it has become the object of intense surveillance. A further, historical and theological concern has been the discourses around the function of heterosexual intercourse as primarily or the vehicle for procreation, and/or the instrument of recreation. Biological determinists and fundamentalist Christians might cite the dominance of the selfish gene argument whereby it is the effectiveness of the (timely) delivery of sperm to fertilise the egg that should be privileged over the contemporary discourses that locate extensive foreplay, lengthy penetration and orgasm as the prime mode of achieving pleasure, meaning and self-actualisation. Within increasingly globalising and sexualised societies, the valuing of elaborate and lengthy sexual interactions permeate people's expectations. This distorts the assumption of what is normal, and emphasises the risk of the individual person failing to fulfil their erotic performance.

What is clear is that the two dominant perspectives, medicine and psychiatry appear

to continue to adopt opposing theories to the clinical management of PE but have not acknowledged that the contexualisation of the condition (symptoms, syndromes and their management) must be embedded in local constantly evolving cultures. The emergence of evidence-based literature exacerbates rather than draws together the disparity between the two competing ideologies and negates the subjective experiences of the individual person.

Conflict of interest

Neither of the authors has declared a financial interest in a company which manufactures, distributes or is developing drugs of the type mentioned in the manuscript.

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