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Unemployment is only one manifestation of our disintegrating society. The general practitioner, with his finger on the pulse of the people, is in a good position to observe the change that is taking place—economic, social, psychological, and spiritual change—change that we can barely recognise in our society. There is perhaps some consolation in the thought that this has happened before. Barbara Tuchman in her book *A Distant Mirror* compares our present plight with the "violent,

Sex Problems in Practice

Premature ejaculation

ELIZABETH STANLEY

Definition

Premature ejaculation has been defined in many different ways, such as when ejaculation occurs before or within 30 seconds or two minutes of vaginal penetration taking place, or after less than 10 intravaginal thrusts of the penis. Masters and Johnson¹ were the first to consider the woman in its definition and suggested that the man was a premature ejaculator if he did not last long enough for the woman to reach orgasm during intercourse on 50% of occasions, although acknowledging that this definition would not be appropriate if the woman was non-organic for reasons other than premature ejaculation. Essentially, however, premature ejaculation is the absence of voluntary control over the ejaculatory reflex, regardless of duration of penetration, number of thrusts, or frequency of the partner's orgasms.

Presentation

Premature ejaculation itself is usually the presenting complaint, but sometimes it is impotence instead and only on careful questioning does it emerge that the real problem is ejaculation occurring with little or no erection before penetration can take place. At other times true impotence is the problem but turns out to have had its origins in past premature ejaculation. In some women who present with lack of sexual responsiveness or failure to achieve orgasm, or both, their partner's inability to control ejaculation may emerge as the main contributing factor. There are even men who are unaware that "coming" very quickly can be a problem, and actually regard it as a sign of their virility.

Organic causes

As with all sexual presenting symptoms, organic causes (although rare with premature ejaculation) must be excluded before psychological ones are considered. Particularly when ejaculatory control has previously been good, any neurological disorders or localised genital pathology such as prostatitis need to be excluded.

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tormented, bewildered, suffering, and disintegrating age of the fourteenth century, a time, as many thought, of Satan triumphant."

And what can we do about it in the practice? Little enough, I am afraid, and yet the general practitioner, although he has changed and his system of medical care has changed, may well have retained a function which he has had for a thousand years, of being someone to whom the patient can turn in adversity.

Psychological causes

Freudian theory postulates that the premature ejaculator harbours unconscious but intensely sadistic feelings towards women; the unconscious purpose of rapid ejaculation is to defile and so to deny, incidentally depriving her of pleasure. Masters and Johnson¹ contend that early sexual encounters under stressful conditions when unwanted discovery is always imminent—such as making love in the back seat of a car—are predisposing factors, as are experiences with prostitutes whose only aim is to get on to the next customer as quickly as possible. None the less this does not explain why only a proportion of men with these types of early experience subsequently develop premature ejaculation. Marital problems can undoubtedly contribute to it or cause it, but often resolving the marital conflict alone does not alleviate the premature ejaculation. Some believe that anxiety is the basic problem and others that there is excessive sensitivity to erotic sensation. The explanation most closely in accord with my own clinical experience, however, which is the antithesis of the last viewpoint, is that put forward by Kaplan.² She says that the crucial aspect of the problem is that the man has failed to allow himself to receive the sensory feedback of those sensations that occur immediately before orgasm which would enable him to bring his ejaculatory reflex under voluntary control. She compares the process to that of a child gaining voluntary control over bladder function, which cannot be achieved without the child first appreciating the sensation of a full bladder, and points out how any organic impairment of sensation from the bladder results in loss of voluntary control over its function. Likewise, she suggests that lack of awareness of pre-ejaculatory sensations prevents a man from bringing his ejaculatory reflex under voluntary control. Indeed, once intensely aroused many premature ejaculators lose all awareness of erotic sensation and develop a kind of genital anaesthesia.

Principles of treatment

Psychoanalysts have believed that the only effective treatment was prolonged analysis in which other than conscious processes thought to underlie premature ejaculation are uncovered and resolved. Usually "first aid" measures, such as thinking about income tax returns or biting a lip painfully hard, have been tried to distract the man from thoughts of the strength and intensity of his erotic sensations. Unfortunately these seldom work, and

his penis firmly for 15 to 20 seconds with her thumb placed on the frenulum and her first two fingers on the other side of his penis, just above and below the coronal ridge. The pre-ejaculatory sensations will then be lost and the erection may diminish slightly. Stimulation is then resumed and the squeeze reapplied when orgasm is again thought to be near, and this is repeated three or four times after which the man may ejaculate if he so wishes.

It is emphasised that at no point should the man try to exert voluntary control over his erection, but rather to signal to his partner to stop stimulation, as this would defeat the object of this exercise. Instead he is encouraged to focus on the good feelings he is experiencing in his penis, which often provokes the response, "But that's the exact opposite of what I thought I should be doing!" In subsequent sessions a lubricant such as KY jelly may be used to simulate the sensations produced by the woman's vaginal secretions, and the squeeze may be abandoned in favour of simply stopping and starting stimulation. This procedure should be repeated daily, or as nearly as possible, until the time between starting stimulation and feeling the desire to ejaculate has increased appreciably, at which time the couple can proceed to the next stage.

SECOND STAGE

General body pleasuring should be repeated, and then, with the man lying on his back, the woman kneels astride him, leaning forward slightly so that an insert his penis into her vagina and gradually move backwards on to it. To begin with she does not move so that he can get used to the simple but immensely pleasurable sensations of being still inside her vagina, feelings he has not often appreciated before. If he feels he is near to ejaculation he tells her, and she rises up off his penis and waits until this sensation diminishes. If wished, the squeeze may be applied at this point with the woman holding his penis against her vulva. Penetration is then resumed, and the woman gradually moves up and down on his penis until he signals her to stop. As he gains increasing control he gradually starts to make thrusting movements himself, stopping and starting as sensations dictate. This is repeated three or four times in any one session, after which he may choose to ejaculate. Again this needs to be repeated daily if possible, and as the man gains further control he may simply slow down his thrusting instead of stopping each time he feels the need to ejaculate. Kaplan recommends using the "stop-start" technique in the lateral position before moving to the male superior position; although I do not usually find this necessary, it nevertheless can be an enjoyable position to introduce to the couple. If only the squeeze technique is used throughout it must be explained that when normal intercourse is resumed thrusting will always need to be regulated to some extent to avoid ejaculating before it is desired. It is important to clarify that the squeeze does not physically hold back the semen, but only aids in the recognition of the pre-organic sensations.

If these techniques are used regularly voluntary control over ejaculation is usually achieved in a few weeks, although the techniques may need to be repeated at intervals over the next few months. The enhanced level of communication that also results from the "homework" is an added bonus, often improving the general quality of that couple's relationship in an unexpected and delightful manner.

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Profiles of Practices

No two alike

KEVIN ILSLEY

It's fashionable to criticise vocational training and question its relevance to everyday general practice, so I hesitate before admitting that I have enjoyed my trainee year and found it instructive. I suppose that living in a pleasant part of the country helps. From a distance Malvern looks strangely un-English, clinging as it does to the slopes of the Malvern Hills. Yet it is the most English of towns, with an air of faded elegance. It was once famous as a spa town but now is better known for its many schools. The population swells by the thousands in term time, giving some practices a lot of extra work—and, of course, extra income. A large proportion of the population is elderly; many of the large Victorian and Edwardian family houses now serve as nursing homes and people still retire here, attracted by the scenery but curiously underpinned by the steep streets. Almost 20% of the practice's 7500 patients are over 65 years of age.

There is a little light industry in the town—the marvelously anachronistic Morgan sports car is made here—but the Ministry of Defence is the largest employer. I was surprised to find so many doctors on the practice list before I realised that they were PhD research scientists at the Royal Signals and Radar Establishment, which seems to employ thousands. There is no other large employer, but many people commute to Worcester or to Birmingham.

The town attracts many visitors. Hordes of people tramp the hills, and the recently revived Malvern Festival brings people into the town during its two-week Spring run. The Festival ensures the viability of the theatre, which gives the practice an added interest—it is on call for any emergencies and a routine day's calls are sometimes relieved by having to treat, for instance, a ballerina's sprained ankle or a singer's strained throat. The town is well served medically, with three group practices and three single-handed doctors. There is a small hospital with x-ray and physiotherapy facilities at the disposal of general practitioners, a GP-run casualty department, and 18 medical and surgical beds.

My country practice

The three partners in my training practice rebuilt their own premises a couple of years ago. It is a pleasant, one-story building, set back from the road—one of the leafy avenues that run from the centre of the town. A glass-fronted receptionist's office looks out on to a small entrance hall from which patients are directed to one of the three waiting rooms that are attached to the partners' consulting rooms. Trainees are something of an afterthought, and "my" room doubles as a treatment room used by the two attached community nurses and the health visitor. There is a practice manager, who shares a spacious office with a

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couple of secretaries. It is a friendly practice. The doctors get on well with each other and are on first-name terms with the staff, and I was made very welcome.

Though the three partners get on well with each other they are all very different. My trainer is in his late forties, a trained psychiatrist and psychotherapist, who not surprisingly tends to adopt a psychotherapeutic approach to problems. The senior partner has been in the practice longest but is 10 years younger than my trainer. He and the third partner, who is about my age (that would be telling), have a more system-orientated, organic approach—a combination that I think I feel works to the patients' advantage since they can choose which doctor they want to see, and they seem to select the partner most suited to their needs.

I am sure it has been an advantage to be the first trainee in the practice. Some of my friends think that the trainee label affects their relationship with patients, who realising that they are temporary tend to present only short-term problems. But I felt that I was treated as just another doctor by patients and staff alike and was exposed to a broad spectrum of practice. I was pleased that I didn't have to cope with the disadvantages faced by one of my friends who found a notice in his waiting room that read, "Doctor X is a trainee general practitioner attached to the practice for one year. Please co-operate and agree to see him if asked to do so."

Malvern presents a middle-class face, and I wasn't surprised to find a large number of professional and business people among the patients. But there are areas of social deprivation here, too, and we have our share of social problems—though I am not sure that problems are necessarily confined to a particular social class. The practice has a higher-than-average home visit rate, probably because there are so many elderly people on the list. Most of the patients are drawn from the town, but even when driving round the town the countryside there is a pleasant distraction, the hills but a glance away. Enough patients are in the surrounding countryside to make rural cases a commonplace, and I enjoy getting out of the town—pleasant though it is—and tramping round farms for a change.

An inner-city practice

I have been encouraged to get out to look at other practices—maybe my trainer's been trying to tell me something? He used to work in London and arranged a week's exchange with the trainee in his former practice. I was quite happy in Malvern but found myself overcome with a masochistic urge to see what life was like in an inner-city practice.

The differences between the two practices were jarring; the many similarities took a little longer to register. Whereas Malvern practice premises were owned by the partners, my three London hosts shared part of an enormous, impersonal modern health centre with two other practices, dentists, health visitors, and radiologists and upstairs the department of general practice of one of the London medical schools. Instead of easy

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waiting rooms there was a large open-plan waiting area designed to be shared by all patients—sensible use of space. Not all "senior" ideas work though, and the practice had managed to get permission to convert a room that was closer to their consulting rooms into "their" waiting room, giving the practice a separate identity that I think must have lacked before.

Though the premises were different I found that the staff had much in common. I was warmly welcomed by the reception staff, who seemed amused at the idea of a "country trainee" coming to the big city. The partners were friendly and quickly put me at ease. There were two male partners and one "lady doctor," who all seemed to get on well together. During the week I was impressed by their medicine and their sympathy for patients, and by the fact that they had "the bad doctors" who are supposed to inhabit the murky recesses of inner cities. In the consulting room it was difficult to see what difference there was between inner city and country practice. True, the patients' stories were different. I found that the problems were presented and dealt with in much the same way that I was used to. But I noticed that there were fewer elderly patients and more single people without any local family support. Away from home the patients seemed to have a more earnest talk about the problems of social isolation and discussion about the role of the primary health care team. When was intervention appropriate? Should there be a scheme to introduce isolated pregnant mothers to each other for instance? This was all rather alien to my appreciation of practice at home where social problems certainly existed, but where there was still some vestige of community and family support.

Outside the practice the contrast was more striking. It did half way between Euston and Paddington amidst a jumble of decaying Victorian buildings and modern tower blocks. Most of the patients lived relatively close to the practice, though distance is meaningless in London. I had forgotten the frustration of inching through London traffic, all the more frustrating when trying to visit a patient who according to the map lived a mere car hop away. Then to find patients in obscurely numbered flats, in identical-looking, idiosyncratically-named tower blocks.

Maybe it would have been easier with time. What I don't think I would ever have found easy is dealing with London hospitals. We are fortunate in Malvern to enjoy good relations with the local hospitals where most of the consultants are known personally to the general practitioners. The voices at the end of the London telephone were impersonal, unhelpful—did I sound so pompous when I was a houseman in London? I was reminded of the teaching hospital role that general practice medicine is second-class medicine, city general practitioners are best incompetent and at worst dangerous, to be kept at arm's length. I was conscious of a great gulf between the hospitals and the community they served—a subjective reaction and perhaps unfair after only one week's exposure to one London practice.

The surgery in Malvern was no more than 10 minutes away from any of the partners' houses. At the end of the London day the surgery was locked and the partners went their separate ways, joining other commuters on their way to the outer suburbs. I imagine it's difficult to live close to a central London practice because of property prices, but none the less I was left feeling that it was more difficult to practise a high standard of medicine when doctors live at a distance from the area they serve. I was conscious of a great gulf between the hospitals and the community they served—a subjective reaction and perhaps unfair after only one week's exposure to one London practice.

Private medicine

Before I left I had the opportunity to watch a private general practitioner at work. I went to South Kensington intending to be

critical. I am unhappy with the idea of private practice and conjured up an image of a smooth operator interested only in making money out of his unfortunate patients. But posturing seemed inappropriate once in the practice—a converted basement in a residential block. I was bowled over by the enthusiasm of this particular general practitioner. He worked with a manic energy, finding time between patients to lecture me on the evils of the National Health Service. Yes, he had worked as an ordinary general practitioner for 12 years before coming to the conclusion that the system was wasteful, inefficient, and stifling. There was no incentive for general practitioners to practise good medicine—indeed pay rises came regardless of the quality of care provided. Lack of equipment and surgery facilities meant expensive, unnecessary referral to hospital specialists, who carried out investigations and procedures well within the competence of the average general practitioner. Should he dig into his own pocket to improve his surgery and widen the range of services he is able to offer, his enterprise goes unrewarded. Sloth and inactivity are encouraged—so the message ran—and the most energetic thing the average general practitioner does is write prescriptions.

He was certainly a persuasive preacher and almost had me converted. I was impressed by his surgery with its x-ray equipment, pathology lab, electrocardiograph, audiometer, and staff to run it all. There was a physiotherapist, a lab technician, practice nurse, secretaries, and, of course, an Arabic interpreter. But the clientele was by no means exclusively foreign. There was a very brisk demand from ordinary Londoners, apparently as dissatisfied with the NHS as their doctor was, who were more than willing to pay the modest fees. The whole enterprise was paid for out of fees, but I don't understand why they were not higher than they were. Perhaps it was possible because the working day was so long, running well into the evening and finishing with a session with visiting consultants who provided second opinions. I am not sure where the elderly, the frail, or the handicapped fitted into such a system but was impressed in spite of myself by the quality of the care that was delivered. I was left wishing that this brand of extended primary care was feasible with the NHS.

I'm not sure that I have learnt any more medicine in my trainee year than I would have done had I joined a sympathetic practice as a partner instead. But the year has made it possible to take a broader view of practice. I have enjoyed visiting other practices and have a much clearer idea of the sort of practice I would like to work in. My only problem now is to find it.

Domiciliary problems

One of the critical things when you get a consultant out to do a domiciliary visit is that you must make certain that the patient tells him the story they told you. I once saw a middle-aged woman who had been vomiting and obviously for three weeks. Those were the days when you couldn't get quick outpatient appointments, and basically she needed a barium meal. I called out a senior consultant, a remarkable man who had been in general practice, saw the woman the day before and I examined her. The consultant came and he could see, as I said, that she was pretty ill, and he said to her, "Well my dear, what is it that's been the trouble?"

She replied, "Well, doctor, it's these lumps on the back of my head." He put his hand there, and he felt the bony secondaries. I'd been going in there for three weeks. She was a friend of mine, and she hadn't once mentioned it to me. As we went out the consultant put his arm round my shoulder and said, "Ken, don't worry, it happens to us all."—KEN DIXON, general practitioner, Birmingham.

We will be pleased to consider for publication other interesting stories about general practice.—Ed, BMJ.

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the reason why can readily be understood if Kaplan's theory of causation is accepted. Other tactics that aim to diminish sexual sensations and delay the onset of high levels of arousal include the use of condoms, alcohol, sedatives or other drugs, and anaesthetic ointments; but these are not to be recommended because if they work at all they do so for only as long as the particular agent remains in use. Masturbating before intercourse takes place and behavioural techniques aimed at reducing anxiety are two other approaches that seem to have only limited effectiveness.

The two most successful methods of dealing with premature ejaculation are the "squeeze technique" described by Masters and Johnson¹ and the "stop-start" method evolved by Kaplan.² Both are based on a technique developed in 1956 by a urologist, James Semans. Central to their success is the fact that both methods repeatedly focus the man's attention on the sensations immediately preceding ejaculation. They are, in effect, techniques of "biofeedback" similar to those used to regulate automatically controlled bodily functions such as pulse and blood pressure, hitherto thought to be beyond voluntary control.

Both the "squeeze" and the "stop-start" techniques seem to be equally effective as each carries with it the same essential ingredients. I personally combine the two in a modified form, preceded by the treatment strategies of education, "permission-giving," and facilitating communication that are mentioned elsewhere,³ and have not yet had a treatment failure. In young couples and in couples with a basically sound relationship however, use of the squeeze or stop-start alone may be all that is required and these measures are likely to be all the treatment that is needed, and they could easily be used in routine general practice. With some couples, however, resistance to treatment may be met, often at a point when progress is becoming apparent. This unconscious sabotage may declare itself in many different ways, such as the man bringing home mountains of work from the office, or the woman finding excuses to avoid doing the "homework." Often merely interpreting this process to the couple is enough for the treatment to proceed. Sometimes, however, such resistance may reflect deeper underlying problems hitherto unrecognized, in which case it is necessary to clarify and resolve these problems before continuing the treatment for premature ejaculation. This may be more time consuming than is compatible with general practice, and many may feel that they have insufficient skills to continue at this point. If the couple is then referred elsewhere it is important to assure them that the treatment has not failed but has brought to the surface other problems that require specialist intervention.

If the woman also has her own sexual problems it is important to explain that she will not be forgotten, but the first and possibly the only step required for their resolution is to deal with her partner's premature ejaculation. If necessary, though, treatment strategies described elsewhere³ may be used subsequently to help resolve her problems.

Treatment procedure

FIRST STAGE

The couple is asked to set aside plenty of unpressured time for the "homework," which begins by the couple caressing each other's bodies in ways that are mutually pleasurable. More structured "sensate focus" exercises may be given if preferred. The man is then asked to lie on his back, as relaxed as possible and with a passive frame of mind, thinking only in terms of receiving. The woman then proceeds to stimulate his penis until he feels he is near to reaching a climax. Masters and Johnson¹ describe the point of ejaculatory inevitability (put more simply by one of my couples as "the point of no return") after which ejaculation will occur regardless of almost any circumstances. The man needs to become aware of this point, and just before it is reached he signals to his partner to stop the stimulation. In the early stages I usually suggest that she also squeezes