# Impotence

The male cannot obtain or maintain an erection satisfactory to him for the purposes of heterosexual intercourse.

The following are three classifications of impotence on the basis of etiology:

**a)** Organic disease causing impotence (anatomic abnormality; neuralgic disease , systemic disease; trauma; either accidental or surgical, and hormonal deficiency);
**b)** Chemical, or medical impotence (drugs of a narcotic or sedative nature, morphine, alcohol, and medicines like anti-hypertensive, etc)
**c)** Psychological impotence

However, what is mist interesting is that of two men with exactly the same organic problems and the other none at all.

Despite the large number of known organic causes, most authorities seem to agree that most of the causes of impotence stem from psychological reasons. One point that most agree upon is that anxiety or fear seems to play an impotence problems as the result of conditioned anxiety, and treatment as largely aimed at reducing the anxiety associated by the approach to sexual intercourse.

Treatment for impotence includes psychoanalytic therapy, rational – emotive therapy, hypnosis, and mechanical means such as splints, vacuum devices, and artificial phalluses, poetic ‘hypnograms’. Post hypnotic suggestions and long term psychotherapy.

Learning oriented approaches usually use graded sexual responses in the actual sexual situation, if some sexual arousal is reported, or systemic desensitization if no arousal is

present. Salter (1961) has reported success in using combination of assertive training, and blended imaging. Wolpin (1969) has reported good results with his techniques of guided imaging.

Cautela describe successful results by using covert negative reinforcement. His impotent client was asked to imagine an aversive scene, such his boss yelling at him, and then hi was immediately switched to a scene in which he as lying in bed and naked relaxed next to his wife. More recent treatment has been based on a abroad spectrum coverage, such as the combined use of thought stopping, systemic desensitization and sexual assertion.

Problem in this area usually begin with some participating event such as the following fatigue, preoccupation, jet lag, overdrinking, criticism by a partner, being bored with partner, having a non – attractive partner, worry over early ejaculation, fear of disease or pregnancy, guilt over masturbation, home sexual responses, unfaithfulness, anxiety associated with expected performance either by the partner or the client himself. Whatever the participating event it is male's reaction to it that will most likely affect subsequent performance. He begins to doubt his 'manhood' and he becomes anxious through the self – labeling process. He will approach his next sexual encounter with a great deal of anxiety and worry commonly called 'fear of performance', which also effectively blocks his normal arousal system and thus results in another failure. Once this chain starts to function, it can be quite difficult to break.

It is important to know under what circumstances the client experiences erections (e.g., fantasy stimulation, tactile stimulation, alone, with partner, etc.) Treatment from a learning point of view is usually directed at reducing or eliminating the anxiety that is associated with the approach to sexual activity through paradoxical intention or successive approximation principles. The following treatment suggestions are divided into three categories: (1) the male (2) the female (3) the couple. The man should be encouraged to have his partner come in with him and the woman similarly. When

the couple comes in together and both are willing to cooperate with the treatment suggestions, there is always a higher probability that they will achieve their goals, At Karachi Psychiatric Hospital we assure that the wife will be seen by a female therapist only and this results in more wives accompanying their husbands for sex therapy.

### (a) Suggestions to the male

Reassure the client that almost every man has a problem with his erection on some occasion or other. It is further suggested that the client be asked to inform his partner of what he has learned and what he has been asked to try so as to enlist her cooperation. The initial suggestion that may be given is redirection of attention, that an erect penis is not particularly necessary for mutual. sexual gratification and this may encourage the client to explore other options. The clinician can further remind him that he still has his hands, fingers, legs, arms, mouth, lips, and tongue and that any area or combination thereof may be stimulating to his partner, possibly to the point of orgasm. In this way his own natural arousal system may begin to function again and he may obtain an erection. However, he should be warned not to try penetration whenever this erection occurs as there is always another time. An alternate suggestion is one called ‘suffering’. He is asked to engage in whatever behavior that he and his partner desire, and at some point when he is feeling comfortable and perhaps aroused to some degree, he or his partner literally "stuff" his penis into the vagina. There is no goal, other than pleasurable sensation for both. If he should "happen" to find that he has an erection, certainly enjoy the experience but that is not the main point of the suggestion and he is not to continue further if he feels the least bit anxious about his erection. The third suggestion is graded sexual response. He is told to engage in mutual sexual gratification with his partner, as often as possible, in whatever way that he and his partner would like, up to the point where he

experiences his first sign of anxiety. At that point he is to stop. The couple can relax, cuddle, share a drink, take a shower together, or whatever else they would like. Then, start again, However when he experiences the first sign of anxiety he is to stop whatever he is doing or about to do and return to the earlier action where no anxiety was present. The partner can experience orgasm through whatever means both feel comfortable and pleasurable. He is instructed to gradually keep trying to extend his session past the point where he felt the anxiety, but he is always to stop when his anxiety begins, remembering, there is always another day.

For self stimulation he has to involve himself in whatever activity or stimulation that has been arousing to him. This may invo1ve seeing sexy movies and pictures, reading books or using sexual fantasies. Whatever he finds arousing he I given "permission" to use, and at the same time he is to actually stimulate himself in the way that brings on the most pleasurable feelings. It may help to suggest to him that rather than use his dominant hand in self - stimulation he is to use his non - dominant hand. In other words, if he regularly uses his right hand for self - stimulation, he is asked to start using his left hand, or vice versa. Many clients report highly positive results because this provides a "different" penile sensation and that the penis feels much larger than before. Assuming that a level of 40% erection is reached, then henceforth, he is to use whatever fantasy or visual aid, that he likes, and he is to stimulate himself in the way that he finds most arousing, but he is not to experience orgasm unless he obtains an erection of more than 40%. If, at a particula1 session he is unable to reach 40% and he becomes fatigued or bored, he is to stop, remembering that there is always a next time. Gradually, by following these successive approximation procedures, he may eventually reach a full erection with such self - stimulation. For the client who has no difficulty with erections through self - stimulation, or has now learned to obtain them, it is suggested that he start systematically to use fantasies during such self -

stimulation that involve him having a firm erection while engaging in sexual behavior with a partner. When the client is able to become involved with a partner, then the suggestions given previously for men with partners may also be given to him. Conversely, where appropriate, these suggestions can also be given to men already involved with partners.

### (b) Suggestions to the female

In the case the husband has fear of performance the female client may be advised to deliberately stimulate him in different situations, besides formal sexual intercourse, e.g. while driving a car, or sitting for dinner or watching a movie etc. She should be encouraged to continue to engage in regular sexual activity with him without any expectation of performance on his part, other than to just share some pleasurable activity together. She may also be given some other suggestions, like in a partial erection, if the penis is pushed downward, pressure and stimulation are increased and the erection becomes more firm. Stimulation of the base of the penis also puts pressure on the major blood vessels to retain blood. In the woman underneath position, raising the level of the vagina with pillows or pads beneath the buttocks may be initially helpful. The woman on top position is also helpful, for it allows insertion and a firmer vaginal hold even on a partial erection. In this way she can provide most of the initial movement stimulation. Other positions that may be helpfu1 in promoting erection are the cow and bull position with rear entry to the vagina, side by side, the face to rear positions, or the woman on her back and drawing her knees up before parting her legs.

### (c) Suggestions to the couple

The treatment of impotence will be outlined according to the number of sessions conducted with the couple. In the following format the sessions may not automatically follow each other, for if it is felt that the husband and wife have not

mastered and enjoyed a session, it should be repeated until pleasurable. Thus the treatment duration will be different for different couples. For best results husband and wife should be residing in a hotel or a hospital but if this is not possible they may attend the out patient clinic twice a week or as often as they can come. In newly married couples, wives are seen only once or twice or not at all as they cannot leave the house repeatedly, without arousing concern in the family.

**Session No. 1(a) History**:

(i) Psychiatric (ii) Sexual

History taking involves more than the standard psychiatric interview. Basically it comprises of a detailed inventory of sexual attitudes and experiences in all phases of life, along with similar data of the marital partner and their mutual psychological and sexual interaction. The sexual history questionnaire is printed at the end of this book.

**(b) Examination:** (i) General (ii) Genital

After a complete physical examination, the genitals are also examined, for the satisfaction of the patient, as well as to rule out any local pathology, for it seems most patients have a mistaken feeling that their genitals are either not fully deve1oped or that they have been deformed by masturbation and other imagined sexual abuse. In the vast majority of the cases the genitals are absolutely normal and the patients should be informed of this in an emphatic manner, in order to alleviate anxiety about this matter.

**Session No. 2 Sex Counseling**

The couple is told that the cause of sexual problems is mutually shared and the treatment of these problems can only be brought about my mutual efforts and co-operation. Attempts are made to resolve misunderstanding and conflict between the husband and wife, if any, and to create an atmosphere of understanding, love and affection.

The anatomy and physiology of the male and the female sex organs is demonstrated to them through

explanation and use of pictures. Then it is pointed out to them that sex is pleasurable and that sex between husband and wife is considered equivalent to worship by Islam They are also encouraged to express their feelings about sex to each other, including feeling of pleasure.

**Session No.3**

Then they are both instructed in the sexual exercise called "sensate focus". The husband and wife should be relaxed in their bedroom and completely naked. The husband is instructed to fondle, massage and otherwise rub with his hands the body of his wife in order to give her maximum pleasure. In this session it is advised that the breast and the genitals not be touched. This session should be continued as long as it is pleasurable for both the partners, with a maximum of about half an hour.

After that the wife is to perform the same pleasuring to her husband but it is advised that the genitals not be touched. The husband and wife are to guide each other verbally and non-verbally as to the parts of the body and methods of touching that give the most pleasure.

The couple should use their favourite perfume and the bed room should also be properly decorated, in order to increase the sexual and sensate stimulation.

**Session No. 4**

The therapists discuss the experience and feelings of the previous session. If that session was not enjoyed by both it is repeated, otherwise in this session the partners are now allowed to touch the genitals and breast in addition to the whole body. In order to facilitate the stimulation of the penis by the wife it is suggested that she apply a little oil or cream for that purpose. The husband and wife are now encouraged to have a good look at the sexual anatomy of their partner, specially the husband, who is asked to have a close look at his wife's genitals, so that no doubt about the exact structure lingers in his mind. Husband and wife must also guide the

stroking hand of their partner and indicate directly the parts of the body and the type of stroking that gives the maximum pleasure specially, in the area of the genitals.

## Session No.5

Experience and feelings of the previous session are discussed. If the couple enjoyed that session then this session is advised, however whenever this session is practiced, it must always be preceded by session No.4 as given above. It is pointed out to both husband and wife that erection cannot be voluntarily caused. When stroking of the body specially, the penis, automatically leads to erection, it is suggested that the marital unit enjoy this return to erective prowess by experimenting with the erective reactions. This is called the "teasing technique" and this includes manipulative play to cause an erection, cessation of the play to allow a period of distraction for the male with consequent loss of erection then return to play and resurgence of erective attainment. This should be continued for about half an hour, in a slow non-demanding fashion.

## Session No.6

Repeat, session No.4 and session No.5. Then the husband should lie down on his back and the wife should sit on top of him in such a position that her knees are at or below the husband's nipple line and then she should initiate penile p1ay and the teasing procedure. However, if a full erection is obtained, she shou1d insert the penis with her own hands into her vagina.

### Treatment of impotence

### (Master & Johnson – session N0.6)

Even during the insertion into the vagina, she should continue active manual manipulation of the penile shaft. Both husband and wife should quietly enjoy the pleasure of penile containment in the vagina. No thrusting movement should be made by either partner

and the position should be maintained for as long as it is enjoyable to both.

**Session No.7**

Repeat, session 4, 5 and 6. However, when the penis is inside the vagina, the wife is asked to move slowly up and down on the shaft of the penis. Then she in turn should remain without movement and the husband is encouraged to thrust slowly, concentrating on the sensate pleasure to be derived from the feelings of vaginal containment and warmth, and the sensation engendered by his wife's lubrication. This should also be continued as long as desired by both.

**Session No.8**

Repeat, session 4, 5, 6 and 7. Then both partners are encouraged to move to simultaneous pelvic pleasuring, feeling, and thinking, concentrating only on the sensations involved in this mutuality of their sexual stimulation. There must not be concern for satisfying the wire or forcing ejaculation by the husband. When the end point of sexual functioning comes during coition, it should be by chance, involuntarily, naturally and mutually rewarding, but never by direction.

## Conclusion

Usually, when the couple comes in for the next session, they somewhat sheepishly report that they did not quite follow instructions. The first session is generally reported as initially embarrassing, then fun, and finally arousing. By the second or third session the male is usually experiencing full erection and having a difficult time refraining from genital intercourse. Many times they are so happy about the situation that they say "to hell with the instructions" and go ahead.

For those few cases where the couple managed to refrain from genital intercourse but now request it, the clinician can suggest that they continue on the same program for one more week unless the male has an "overpowering urge" to have genital relations, and if he does, he may go ahead.

*(1) May Allah bless with eternal peace*
*(2) May Allah be Pleased*