

TREATMENT OF SINGLE IMPOTENT MALES

K. KURUVILLA¹, M. D., M. R. C. Psych., F. A. P. A., Dip. IAPCP.

SUMMARY

A behaviourally oriented treatment programme for single males presenting with psychogenic impotence is described. The treatment consists of sexual-re-education, guided imagery and masturbatory conditioning. The immediate results as well as the results of long-term follow up of those who completed the treatment are found to be encouraging.

Behaviourally oriented sex therapy techniques like those advocated by Masters & Johnson (1970). Wolpe (1973) and Annon (1976) have proved to be the most effective method of treating impotent males. In all these methods the cooperation of the patients' spouse in the treatment is enlisted and her understanding and whole-hearted participation are essential ingredients in the therapy. But in those patients who do not have a partner or where the spouse is uncooperative and unsympathetic, this otherwise effective technique cannot be used. Masters & Johnson overcame this difficulty by enlisting the help of surrogate partners. But this is invariably beset with moral and ethical problems in any culture and is particularly unacceptable in ours, with its fairly rigid code of sexual morality. But at the same time impotent males who do not have a readily available partner form a significant percentage of patients attending the outpatient clinic of every hospital in our country. The present paper describes a technique the author has been using during the last five years and has found to be useful in helping many of these impotent males without a regular sexual partner.

THE PATIENTS

The typical patient is an anxious looking, unmarried male in his late twenties, who has been masturbating

from his teens and has heard his friends describing how masturbation drains away all his vigour and vitality and feels that gradually this is happening to him also. He feels his semen is not as thick as it used to be and his erection not as good or as frequent because of his 'bad habits'. At this time he also faces the pressure from his parents to get married and settle down. This makes him even more anxious because he feels he is not capable of sexually satisfying a woman and so evades marriage by offering vague excuses to his parents. He confides his problem in his equally ignorant friends who direct him to the local doctor who promptly declares him to be suffering from nervous weakness, often admonishes him for his 'bad-habits' and invariably starts him on vitamins, hormones, etc. Or he may consult the touring sex specialist who comes to his town periodically and the specialist also explains to him how he has lost "sixty drops of blood through every drop of semen" and the patient becomes doubly anxious thinking about the litres of blood he has lost over the years. Often his well meaning friends and occasionally even his physician advise him to test his potency by going to a prostitute. The unfortunate young man visits a brothel, not driven by sexual desire but by the desire to prove his manliness to himself and is anxious about this "final" test. This intense anxiety invariably leads to

¹Professor & Head—Unit I, Department of Psychiatry, Christian Medical College, Vellore-622002.

a total failure of erection and reinforces his misconcepts and aggravates his problem further. He continues his search for more specialists, more potent remedies and further tests.

By the time he reaches the psychiatrist he is intensely anxious and depressed, with an utter sense of hopelessness about self and future and is exhausted both emotionally and financially.

TECHNIQUE

The initial interview is used to obtain a general understanding about the patient's presenting problem, his personal and family background. He is told how he could be helped by psychological techniques. If the state of anxiety is in tense, a minor tranquiliser is prescribed. It is advisable not to have any rigid idea about the duration of the treatment because then most of these patients set a target date within which they have to achieve their potency. This kind of a goal only increases his "performance anxiety" and results in failure of treatment.

In the next three or four sessions, the patient is encouraged to talk in detail about his past sexual experiences and the type of knowledge he has obtained on sexual matters. During these sessions those patients who are found to be considerably anxious and tense are also taught Jacobson's progressive muscle relaxation. He is advised to continue to practise relaxation at home.

The next 2 to 3 sessions are devoted to a process of re-education. Information is given on the anatomy and physiology of human sexual organs and their functions in language simple enough for the patient to understand—often with the aid of diagrams. Emphasis is laid on the role of emotional factors in causing and abolishing erection. Instead

of making this a pure didactic discourse, particular care is taken to correct the specific misconcepts the individual patient has, as well as to explain the role of emotional factors in causing impotence with specific reference to the stressful experiences he personally has had, as revealed during the earlier sessions.

During these sessions the patient is also advised to read erotic stories. He is advised to do this in the privacy of his room ensuring that there will be no outside interference and to pay attention only to pleasure he gets by reading this material and not to the presence or absence of erection. Care is taken to see that patient reads only stories and not the so called books on sexology—because such books are found to give a lot of incorrect information which often confuses the patient and has very little erotic content. After about 5-6 days of this reading, he is advised to fantasise himself in erotic situations following this reading and also to start masturbating. Again the patient is advised to concentrate only on the sensation this evokes and not on the presence or absence of erection. Initially he is advised not to masturbate to ejaculation. He is to masturbate only upto a point short of it, then deliberately allow the erection to subside and then again to restart the imagery and masturbation. Usually by this time patient reports good erection and he is advised to masturbate to ejaculation after 3 or four sessions. He is instructed never to masturbate to ejaculation unless there is a good erection. To enhance the masturbatory sensation two techniques which may be suggested are (1) use of the non-dominant hand and (2) use of a lubricant (Annon, 1976). Both these are combined with imagery. Later the patient may continue to use erotic reading material as a take off point for

his imagery and if he has had at least partially pleasant past sexual experience he is encouraged to imagine that culminating in successful intercourse. The patient is advised not to use his regained erectile power for actual sexual contact until he gets an opportunity to have heterosexual experience without any guilt or fear. Since in our culture, such an opportunity usually exists only with marriage, the patient is advised to restrict his sexual activity to that. At the same time he is also advised not to rush into marriage merely to test his potency but to enter into it after taking all other aspects into consideration.

During the last 5 years, 18 males were taken up for this treatment. The details of these patients presenting complaints and the results of treatment are shown in the following tables.

TABLE I

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|---------------------------------|----|
| <i>Marital Status</i> | |
| Never married | 15 |
| Married but separated from wife | 3 |
| <i>Age</i> | |
| 21 to 30 years | 14 |
| 31 to 40 years | 4 |
| <i>Duration of complaint</i> | |
| Less than 6 months | 2 |
| 6 months to 1 year | 8 |
| 1 year to 2 years | 6 |
| More than 2 years | 2 |
| <i>Previous Treatment</i> | |
| No treatment | 4 |
| Indigenous drugs | 10 |
| Hormones | 4 |
| Vitamins | 12 |
| Psychotherapy | 1 |

TABLE II

| | |
|--|----|
| <i>Presenting Complaints</i> | |
| Impotence only | 13 |
| Impotence & Premature ejaculation | 5 |
| <i>Sexual History</i> | |
| Past history of heterosexual experiences | 11 |
| Past history of masturbation | 15 |

All the above patients were referred by the Urology department of our hospital where organic causes for their sexual dysfunctions were excluded.

Psychiatric evaluation showed presence of occasional full or partial erection in all of them in sexually arousing. (but nondemanding as far as performance is concerned) situations like watching an erotic scene in a movie, reading erotic material etc. Also 14 of these patients reported atleast occasional early morning erection-thus strengthening the possibility of their impotence being psychogenic.

The minimum educational status of these patients were matriculation.

TABLE III

| | |
|--|----|
| <i>Duration of Treatment</i> | |
| 6 to 10 weeks 2 sessions per week | |
| <i>Response to Treatment</i> | |
| <i>Immediate</i> | |
| Dropped out | 5 |
| Partial improvement | 4 |
| Good improvement | 9 |
| <i>Follow-up (6 months to 2 years)</i> | |
| Total number followed up | 11 |
| Maintaining good improvement with no erectile or ejaculatory problem | 7 |
| Needed "booster sessions" | 2 |
| Partial erection | 2 |

RESULTS

Among the 18 persons who commenced the treatment 5 dropped out—2 during the stage of re-education and 3 during the phase of masturbatory conditioning. The first two were patients who kept on insisting that their erectile failure is physical in origin—in spite of the explanation by the urologist and the psychiatrist that there is no organic cause for their problem. The three who reached the stage of masturbatory conditioning reported any lack of enjoyment either from the reading material or from the imagery but there was no evidence of any other psychiatric disorder like depression.

Among 13 persons who completed the treatment 9 reported having full erection at all times when they resorted to the guided imagery and masturbation. 4 others reported partial to full erection during at least half of the occasions when they indulged in the imagery and masturbation. Two among them complained of difficulty to visualise the erotic scenes.

11 of the 13 patients who completed the treatment kept up their contact with the therapist through letters and

periodic visits for a minimum of 6 months and 6 of them up to 2 years. During this follow up period 7 of those who had good improvement and 2 of the partially improved ones reported having good erections. 2 from each group reported occurrence of erections being less satisfactory and well sustained in comparison to the time of termination of treatment. Two of them came for a 2 to 3 weeks' "refresher course" in re-education and guided imagery and improved further. Among the 11 who were followed up five had got married and all of them reported satisfactory sexual relationship with their partners. 3 of them were also given some counselling prior to marriage especially with regard to indulging in sexual activity in a graded and relaxed manner—suggestion similar to the 'sensate focus' techniques advocated by Masters & Johnson.

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