PSYCHOGENIC IMPOTENCE: ITS AETIOLOGY, CHARACTERISTICS AND TREATMENT BY SYSTEMATIC DESENSITIZATION

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SYNOPSIS

This paper deals with the aetiological factors of Psychogenic Impotence, more emphasis however, being placed on the psychological theories. The characteristics of forty cases of Impotence were analysed and discussed. Two cases, one of Erectile Impotence (failure of erection) and another of Premature Ejaculation were treated by the authors with Systematic Desensitization successfully. The "squeeze" technique was utilized for the case of Premature Ejaculation.

INTRODUCTION

The adequacy of sexual functioning in the male depends upon a complex interaction between physiological, hormonal and neuro-physiological factors. Disturbance of any one of these factors may lead to sexual inadequacy. Patients (male) rarely come to a doctor complaining directly of sexual inadequacy. They often give a series of vague somatic complaints, and it is left to the doctor to detect cues from the hints that he is dealing with a case of Impotence.

Probably a principal way in which Impotence is discovered is when the wife of the patient visits the doctor, bitterly complaining that her marriage is not consummated. She may complain about her husband's sexual inadequacy, or vaginismus and dyspareunia, and may result in the doctor sending her to a gynaecologist for a hymenotomy or a vaginal dilation (Ellison, 1968).

Lief (1964), after a thorough study of the subject, commented: "Doctors are woefully ignorant of sex." In a survey of 89 medical practitioners in Torrance, California by Burnap *et al.* (1967), sexual problems of patients ranged from 2-23%, an indication of whether the practitioners were educated enough to orientate their clinical observations to the area of sexual disorders.

DEFINITION OF IMPOTENCE

Masters and Johnson (1966) defined Impotence as an inability to perform the sexual act because of either a failure to initiate or sustain an erection, or a failure to ejaculate intra-vaginally—ejaculatory, erective or conceptive inadequacy.

PREVALENCE OF IMPOTENCE

Kinsey *et al.* (1948) placed the incidence of Impotence at 1·3% of the population by the age of 35 years. By fifty years old, it was 6·7%, by sixty years, 18·4% and by seventy-five years, 55%. The Kinsey report suggested that no fewer than 45% of husbands were dissatisfied with their sexual capacity.

AETIOLOGY OF IMPOTENCE

(a) Religio-Superstitious

Sexual excesses of all types have, since ancient times, been associated with Impotence. Reflecting religious dogma, taboos and superstitions, masturbation has often been indicted as a cause of Impotence (Cooper, 1969). The subject of male potency has long been documented in ancient pharmacopoeia and innumerable traditional prescriptions and aphrodasiacs have been prescribed. Ancient Hindu medical texts (Wise, 1845) stated one class of Impotence as due to 'excessive revelling'. Ancient Chinese medicine advised that women should be approached in 'strict moderation' since 'excessive contact with them produced intestinal heat ending in *ku* disease, an incurable and sometimes fatal condition'.

Masturbation, superstition, witchcraft, curses and sorcery have been blamed to affect male potency (Gauzzo, 1929; Zimmels, 1952).

(b) Physical

In the majority of cases, no gross abnormality has been found but the absence of gross hormonal or neuro-physiological abnormality does not necessarily imply pure psychological cause. Rarely, there may be atrophy or degeneration of the testes.

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Changes following orchitis, epididymitis, more rarely prostatitis are extremely uncommon. Other possible causes may be structural damage to the lumbo-sacral plexus, tabes dorsalis, tabo-paresis, disseminated sclerosis, neuro-vascular syphilis or progressive muscular atrophy affecting the cord. Very rarely is there a failure of endocrine function on a constitutional or involutional basis.

(c) Psychogenic

Sexual inadequacy is a failure to achieve satisfactory coitus. It is thus a problem affecting two persons. The failure may lie in one or both partners, but it is unusual for responsibility to be completely one-sided. Stafford-Clark (1954) commented that Impotence might be the presenting symptom of a deep-seated neurosis, and that there was a tendency for premature ejaculation to be associated with frank neurosis (Cooper, 1968).

Anxiety appears to be the immediate, and precipitating factor of Impotence whatever sociological or psycho-pathological factors may underly it. The individual is either frightened of failing in the sex act or is afraid of women generally. Such a situation lends to a learned or conditioned fear of a distaste for sexual intercourse, which may arise from childhood. Mother may nag or bully, or he may be diverted to homosexuality. Conditioning induced in this way is a learned fear which can be associated with sexual attitudes of the patient (Friedman, 1968).

Chronic or recurrent Impotence brings about psychological stress such as frustration, doubt about one's own masculinity and feelings of inferiority. Since male prestige is often equated to sexual potency (Trethowan, 1963) and this means having power over women, and if this is not bolstered by sexual prowess, sexual inadequacy and inferiority are accentuated.

Masters and Johnson (1966) considered that it was particularly in the young adult males that a culturally imposed fear to control the ejaculatory processes to a degree sufficient to satisfy the female partner occurred. In older men, similar fears and anxieties more often lead to the impairment of the erective processes, the most common anxiety is the fear of failing to perform the sexual act adequately.

Three psychological factors represent the anxiety of coitus:

(i) Reaction to female rejection, often touching off strong feelings of resentment or hostility.

(ii) Reaction to feelings of inadequacy with a persistent insecurity.

(iii) The flight from the male role—a heightened conditioned reaction to the relatively normal initiations, frustrations and demands involved in male-female interaction.

(d) Psychoanalytical

One of the commoner forms of Impotence is said to be the result of an unconscious identification of the sexual partner with an elder sister or mother, leading to the assertion of incest taboo (Strauss, 1950). Psychoanalysts think the anxiety stems from unresolved Oedipal problems. This anxiety and fear is super-imposed on a particular life pattern thereby contributing to Impotence (Griffith, 1948). Fenichel (1945) classified that childhood fear of father over-shadowed adult sexual potency. Likewise Jones (1919) and Abraham (1949) believed that castration anxiety in the impotent male reflected a childhood fear of father and his punishment. Castration anxiety based upon the need to repress Oedipal aims, fear of one's own excitation, fear of loss of partner's love was claimed by Fenichel to be the underlying psychopathology of psychogenic Impotence.

Thus a universal factor in psychogenic Impotence is a frustrated fixation of the libido upon a sexually forbidden mother-figure. The inhibition of sexual arousal rests mainly on incest fixations during the period of infantile sexual development. This mechanism may cause a man to be sexually impotent to his wife (a mother-figure) while he may be potent with other women whom he has little respect for. There is a tendency for the male to inhibit erection when he is particularly vulnerable to such 'sexual threats'.

MALE-FEMALE INTERACTION IN IMPOTENCE

The male's fear of performance can be related to fear and anxiety. With each opportunity for coitus, the immediate and over-powering concern is whether or not he will be able to achieve an erection. He is constantly concerned not only with achieving but also with maintaining an erection of the quality sufficient for intromission. This grave concern discourages the natural occurrence of an erection.

Not only does the husband contend with fears of performance when Impotence is the presenting complaint, the wife also has her fear of performance as well. Her constant concern is that when her husband is given adequate opportunity for sexual extension, he will be unable to achieve and/or maintain an erection. Wives of impotent men are terrified that something they do will create anxiety,

to embarrass or anger their husbands. All of these crippling tensions in the marital relationship are gross evidences that couples are contending with their sexual functions unwittingly, drawn completely out of context as a natural physical function by their fear of performance.

"It should be stated that fear of inadequacy is the greatest known deterrent to effective sexual functioning, simply because it completely distracts the fearful individual from his or her natural responsibility by blocking the reception of sexual stimuli created or reflected from the sexual partner" (Masters and Johnson, 1970).

CLASSIFICATION OF TYPES OF IMPOTENCE

Impotence may be of two clinical groups i.e., acute onset in younger males or insidious onset in older males. These conditions differ significantly in their developmental history and in response to therapy. The classifications of sexual inadequacy are as follows:

(a) Low Sexual Drive

This may be selectively lowered, e.g., a male finds no sexual interest in his wife but does find another woman stimulating. This group tends to be older and there is a slow but progressive decline in sexual activity, both in terms of frequency and also in terms of 'sexual stamina'. These individuals are often sexually vulnerable and are unable to perform successfully unless the situation is conducive.

(b) Erectile Inadequacy or Failure of Erection

There is the inability to produce or maintain an erection sufficient for satisfactory vaginal penetration and coitus. Secondary Impotence may be 'acute' in onset following some traumatic event, or 'gradual' in onset where there is an associated gradual decline in sexual drive. Frequently such subjects feel ashamed and sexually inferior as they are unable to even take the first step to ask help from their partners. In most cases, anxiety develops after, rather than before, or at the time of their first attempt at coitus.

(c) Premature Ejaculation

This is defined as "the inability to control ejaculation for a sufficient length of time during vaginal containment to satisfy the partner at least 50% of their coital connections," (Masters and Johnson, 1970). It is a problem that occurs in the male's early sexual career and is less often of late onset. According to Kinsey, 75% of all males ejaculate within two minutes of vaginal entry. Males of lower social classes tend to ejaculate faster. Members of higher socio-economic classes are more inclined to delay ejaculation. The attitude of the female is crucial. If the female considers sexual intercourse as the primary pleasure of the male, then ejaculation is faster. If she seeks orgasm herself, then premature ejaculation becomes a problem.

Psychoanalysts (Stekel, 1927; Hastings, 1943; Abraham, 1949 and Cooper, 1968) noted that many patients with premature ejaculation were passive in their sexual behaviour, but harboured deep-seated hostility and resentment to their sexual partners.

(d) Ejaculatory Incompetence

Ejaculation may be either seriously delayed or does not occur at all during coitus. In the Kinsey report, there were only six out of 4,108 cases reported.

AN ANALYSIS OF 40 CASES OF PSYCHOGENIC IMPOTENCE

In an analysis of 40 cases of Psychogenic Impotence seen at the Psychiatric Clinic at the University Medical Centre, Kuala Lumpur, sixty-five percent (26) of the subjects presented an acute onset, twelve percent (5) an intermediate onset, ten percent (4) an intermittent onset and twelve percent (5) an insidious onset of Impotence.

Sixty-three percent (25) of the forty subjects ranged from twenty to twenty-nine years of age, (the mean age being 31·3 years) and their duration of Impotence stretched from one week to three years, although 53% sought psychiatric consultation within one year of the onset of the symptom.

Sixty percent (24) of subjects were single males, while thirty percent (12) were married. Indians and Chinese accounted for 40% each of the subjects while the Malay ethnic group consisted of 20%. The lower social class group represented fifty-eight percent (23) of all cases seen and the middle social class group, forty percent (16).

The classification of the types of Impotence are as seen in Table I.

TABLE I

CLASSIFICATION OF TYPES OF IMPOTENCE

Type of Impotence	Number	Percentage
Total failure of erection	15	37·5
Partial erection	13	32·5
Premature ejaculation	11	27·5
Ejaculatory incompetence	1	2·5
TOTAL	40	100·0

Generally, there was no difference between the types of Impotence with marital status, although one married male was able to have coitus with other women, but not with his wife. Erectile inadequacy appeared to be of similar frequency among the middle and lower social classes, but there was a distinct difference for premature ejaculation. Thirty-five percent (17) were from the middle social class, while only twenty-two percent (5) were found in the lower social class group.

The most cases of both types of Impotence were of an acute onset (63%) and less of intermediate onset (12·5%). There were no age differences between the age of onset of both types, both occurring mainly between the age range of 20-29 years.

Forty-eight percent (19) of subjects were self-referred, while twenty-three percent (9) were referred by a general practitioner and twenty-five percent (9) by neighbouring non-psychiatric hospitals.

TABLE II

PRECIPITATING FACTORS TO PSYCHOGENIC IMPOTENCE

Precipitating Factor	Number	Percentage
First attempt with prostitute	8	36·4
First attempt with girl-friend or wife	5	22·7
After infection of venereal disease	4	18·2
Acute Koro attack	2	9·1
Jilted by girl-friend	3	13·6
TOTAL	22	100·0

A precipitating factor was attributed for Impotence by forty-five percent (21) of subjects, the remainder developed Impotence without a traumatic precipitating event.

Fifty-nine percent (13) developed an acute onset of Impotence after their first attempt at coitus with either a prostitute, a girl-friend or during their wedding night (three cases manifested as 'non-consummation of marriage'). Premature ejaculation was commoner for those who visited prostitutes. Three college students developed an acute onset of Impotence after their girl-friends had left them. Further investigations revealed that these subjects suffered primarily from a social inferiority complex and had utilized their girl-friends to boost their self-esteem and masculinity. When their girl-friends abandoned them they reverted to their original situations and therefore developed Impotence.

A history of frequent visits to prostitutes (42·5%), infection by venereal disease (12·5%), excessive masturbation (5%) and premarital coitus (5%) was cited as the main reason given by the subjects for the cause of their Impotence.

Interestingly, 35% of cases described their mothers as 'over-protective' and 42% as 'ineffectual' as opposed to their fathers. Thirty-three percent of subjects were 'eldest' siblings and 28% were 'second' siblings of their families.

TABLE III

FAMILY CHARACTERISTICS OF CASES OF PSYCHOGENIC IMPOTENCE

Family Characteristics	Father		Mother	
	Number	Percentage	Number	Percentage
Alive	32	80	38	95
Dead	8	20	2	5
TOTAL	40	100%	40	100%
Effective	20	50	9	22·5
Over-powering	8	20	14	35·0
Ineffectual	12	30	17	42·5
TOTAL	40	100%	40	100%

TABLE IV

SOCIAL AIM FOR CONSULTATION AND TYPES OF IMPOTENCE

Social Aim for Consultation	Erectile Inadequacy	Premature Ejaculation	Erectile Incompetence	No.	%
Impending marriage	12	4	—	16	40
Marital break-down	9	4	—	14	35
Loss of face with a prostitute	2	2	—	4	10
Other causes	5	1	1	6	15
TOTAL	28	11	1	40	100

The most frequent social aim for consultation for unmarried subjects was an impending marriage (40%), often being arranged by their parents. They had been potent with prostitutes till the realization of the proposed marriage had suddenly dawned on them. The next most frequent reason, i.e., among married subjects, was an impending or a marital breakdown frequently due to sexual difficulties.

Since the loss of sexual function and potent masculinity is a traumatic blow to the male, manifestations of anxiety (57·5%); depression (27·5%) and guilt (7·5%) were common. Only 7·5% presented with no psychiatric symptomatology, but mainly complained of the symptom. Among the 40 cases, 52·5% (21) were not treated at all, mainly because they were unmarried; fifteen percent (6) were placed on anxiolytic drugs, and 22·5% (9) on psychotherapy mainly to allay their secondary anxieties and depression. Only four were treated successfully by behaviour therapy.

TREATMENT OF PSYCHOGENIC IMPOTENCE BY SYSTEMATIC DESENSITIZATION

In the past fifty years or so, many and often ingenious treatments had been introduced only to be discarded and proved to be ineffective. Treatments have included the utilization of a penile splint (Lowenstein, 1947) or a penile brace or male hormones (Hamilton, 1937), hydrotherapy and electrotherapy (Schapiro, 1943). Psychotherapies have included formal psychoanalysis, psychotherapy by reciprocal inhibition, behaviour therapy and sex education (Rachman, 1961). Wolpe (1958) utilized relaxation techniques followed by systematic desensitization, while Friedman (1969) utilized the intravenous injection of Methohexitone Sodium to induce relaxation. Lazarus (1963) treated frigidity by systematic desensitization and counselled abstinence as a method of avoiding resensitization. It has been postulated (Haslam, 1965) therefore that methods of deconditioning should be desirable to remove the maladaptive conditioned response, and since the sexual act is itself pleasurable, once intercourse has been satisfactory, there should be no fear of relapse.

The inhibition of erection may reduce anxiety by removing the threat of a sexual encounter or may increase the anxiety of causing a 'fear of failure'. Ignorance and the anxiety it generates is frequently associated with sexual inhibition.

The necessity of conjoint husband-wife therapy was stressed by various authors (Kraft and Al-Issa, 1967; Masters and Johnson, 1968) and dual-sex therapy teams were more successful. If treatment was directed towards the obviously dysfunctional marriage partner, the 'uninvolved' partner may actually negate therapeutic efforts. Masters and Johnson considered the 'marital relationship' as the patient, since the sexual dysfunction is a marital-unit problem and never only a wife's or only a husband's personal concern.

A dual-sex therapy team avoids the therapeutic disadvantages of interpreting the patient's complaint on the basis of male or female bias. The participation of both sexes contributes to a 'reality factor' to the therapeutic procedure. It lessens the need for the enactment of social rituals designed to gain the attention of the opposite sex therapist. Thus the hazards of interrogation and interpersonal misinterpretation can be by-passed by the employment of a dual-sex team.

TREATMENT OF TWO CASES OF PSYCHOGENIC IMPOTENCE

(a) Case 1

Erectile Impotence and Dyspareunia.

(i) *History*

A thirty-year old male school-teacher was referred by a general practitioner for 'non-consummation of marriage' during a period of three months. He was unable to have proper penile erection during coitus. Furthermore, his wife (*a virgo intacta*) complained of severe dyspareunia. Initially she was to be referred to a gynaecologist for a hymenotomy.

Fore-play produced slight penile erection, but any attempted penetration caused flaccidity of the penis. The couple felt extremely frustrated, upset and anxious and they were unable to discuss their problem openly. Both were rather obsessional, self critical and religious personalities. The husband's father was a very autocratic man while the mother was an extremely possessive woman, more so that mother-father relationship was poor. He started masturbation only one year earlier, had never dated and sublimated his sexual strivings into 'academic successes'. His wife, on the other hand, came from an extremely religious Christian family, and being the only child was taught by her family, church and peer group that sex was 'dirty' and that sexual relationship was only the duty of a wife and for her husband's enjoyment.

(ii) *Therapy*

A total of six sessions (once weekly lasting 30 minutes) of systematic desensitization were arranged for the couple by the authors (who formed a dual-sex team). The first session was devoted to

basic sex education and the introduction to the steps in desensitization. The couple was instructed to discover sensitive erogenic zones on their bodies without genital contact. Penetration was absolutely forbidden, so as to reduce the anxiety of failure and frustration. The subsequent sessions involved a gradual increase in erogenic stimulation of the various sensate zones of each other, ranging gradually from clitoridal masturhation (to orgasm) to gradual digital vaginal stimulation and eventually to very gradual penile penetration intravaginally at each stage. Coitus was forbidden until the last and sixth stage when both partners were ready for full coital connection.

By the last session, the couple was able to enjoy full sexual relations without erectile insufficiency or dyspareunia. They had begun to appreciate sex which acted as a positive reinforcer for each sexual connection. It was at this stage of therapy that they decided to move out of his parent's home as they had also gained insight into the psychopathology of their sexual dysfunctions.

(b) **Case 2**

Premature Ejaculation.

(i) *History*

A thirty-five-year old Chinese school-teacher and his wife were referred by a general practitioner for psychiatric consultation. Since the beginning of their marriage, one year ago, the husband had suffered from premature ejaculation and their marriage was not consummated. He had always been a 'nervous' person and had been suffering from gastric flatulence and a spastic colon. He obtained full erection and stimulation during petting but ejaculated within five minutes of foreplay. He had thus become more anxious and depressed, felt more inadequate and eventually terminated coitus completely, for fear of failure. His wife was a much more stable, understanding woman, whose encouragement turned out to be futile. By the time of consultation, the couple had reached their wits end and were irritable, jointly depressed and frustrated by their marriage.

(ii) *Therapy*

The technique of systematic desensitization employing the 'squeeze' technique was utilized. Joint-couple therapy with a dual-sex team treated the couple for seven once-weekly sessions of 30 minutes each. The sexual act was again broken down piecemeal and the same procedure as in the first case was instituted. Furthermore, the 'squeeze' technique which was first introduced by Semans (1956) was adopted. The wife was instructed to control penile stimulation just short of ejaculation by placing her thumb and first two fingers on the glans penis and applying pressure on either side of the coronal ridge. Rather strong pressure may be indicated to achieve the required result with the 'squeeze' technique. As the husband responded to the adequate amount of pressure applied, he would immediately lose the urge to ejaculate. The procedure was carried out repeatedly until eventually manual stimulation gave way to intermittent vaginal entry, with the woman in the superior coital position.

Coitus was again forbidden through the first six sessions to 'prevent failure and frustration'. The couple was again instructed to progress in the sexual act stage by stage, with the wife applying the 'squeeze' technique repeatedly. By the seventh and last session, he was able to retain intra-vaginally for two to three minutes before ejaculation. By repeated practice, the wife had also learnt to regulate her orgasm with his ejaculation. She no more needed to use the 'squeeze' technique as her husband had achieved a longer refractory period prior to ejaculation.

CONCLUSION

Impotence is predominantly psychogenic in origin and directly related to anxiety and male sexual inadequacy. In an analysis of forty cases, the two commonest types of Impotence were erectile inadequacy (failure of erection) and premature ejaculation. The majority of subjects seen were unmarried and most presented with an acute onset of sexual dysfunction. A precipitating factor was blamed in 45% of all cases, the commoner causes (59%) being the first attempt at coitus. Premature ejaculation was complained of more commonly by males who visited prostitutes. The two commonest reasons for seeking psychiatric consultation were an impending marriage or a marital breakdown.

Generally, the most successful form of therapy had been systematic desensitization utilizing the Masters and Johnson techniques. Two cases, one of erectile inadequacy and another of premature ejaculation, were treated in husband-wife therapy by a dual-sex therapy team. The 'squeeze' technique was successfully implemented for premature ejaculation.

The treatment of Psychogenic Impotence by systematic desensitization is an effective method in the majority of cases.

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