Current Practice

PRACTICAL NEUROLOGY

Guide to Treatment and Short-term Prognosis of Male Potency Disorders in Hospital and General Practice

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There are three main ways in which male sexual potency may be impaired: *impotence*—the persistent inability to develop or sustain an erection sufficient to conclude coitus to orgasm and ejaculation; *impotentia ejaculandi*—the persistent absence of orgasm and ejaculation during coitus (which may be greatly prolonged), despite the presence of normal desire and erection; and *premature ejaculation*—the persistent occurrence of ejaculation and orgasm against volition, and before the male wishes, before or immediately after penetration. Owing to inadequate stimulation by the male partner the female may also experience a reduced orgasm; this is more likely in impotence and premature ejaculation than in *impotentia ejaculandi*.

Disorders of male sexual potency may be predominantly "organic" or "psychological," though in some cases both of these factors may operate and overlap and complicate each other. "Organic" disorders of potency are persistent; irrespective of the type or intensity of the sexual stimulation they remain unchanged. Organic impotence may occur with any debilitating disease—for example, metabolic disorders, disorders of the central nervous system, cardiovascular disease, after the use of drugs, and with endocrinopathies. Most authorities believe that organic disorders are relatively rare and that in over 90% of cases psychogenic factors dominate. This article is concerned with the latter type of disorder.

Most people think that psychogenic potency disorders are best treated by the psychiatrist, psychoanalyst, or medical psychologist. Because of this, the general practitioner—who is often the first to be consulted—might be discouraged from trying to treat these patients, thinking in addition that he is unequipped technically to deal with them, or that their disorders require protracted psychiatric treatment over months or years, or that they have a poor prognosis anyway.

This article, based on some recent findings,^{1,2,3} is designed to reassure the general practitioner that not only are these problems well within his competence, but that they are rewarding to treat. In particular, it aims to help him in the careful selection of patients since this ensures a satisfactory treatment response in a high percentage of cases.

Before starting treatment it is important to obtain a detailed psycho-sexual history from both sexual partners. An essential requirement for successful treatment is the full co-operation and active participation of the female partner; without this it is doubtful whether much can be achieved.

Impotence

Optimum sexual stimulation is that combination of psychological and physical stimuli which allows a man to respond to his sexual capacity. It can be provided only if the male is in an emotionally receptive state of mind and wishes to respond,

and the female partner is willing and able to co-operate fully in providing the type and intensity of stimulation required.

Many men are unable to engage in some types of sexual practices or experimentation because they fear they might be rebuffed as perverted; they are often unable to discuss these matters with their partner. An important part of therapy is to promote frank communication between the sexual partners and to help them to gain insight into each other's sexual attitudes, preferences, inhibitions, etc. This may encourage them to experiment sexually and to improve the variety and intensity of their stimulative exchanges.

Nevertheless, insight—that is awareness that one is not sexually depraved and that one's fantasies and unfulfilled sexual desires may, in fact, be enjoyed by many other perfectly normal people—may make it no easier to throw off restraint and inhibition developed and consolidated over many years.

Treatment is based on encouraging a slow progressiveness, which is always within the limit of emotional tolerance. Thus, an inhibited couple should be advised to discuss their stimulative requirements, degree of arousal, satiation, etc., and to experiment in such a fashion as to become a little more unrestrained and adventuresome each time, so long as this is compatible with "emotional comfort." Nevertheless, they should engage in new practices only when fully roused. To reinforce each new unrestrained pattern of sexual stimulation it is important that satisfaction results each time. If a situation arises, therefore, where any type of sexual experimentation evokes anxiety the couple should discontinue it and revert to a familiar and predictably pleasurable activity. The objective is to arrive at the point, by mutually acceptable experimentation and communication, where each partner has discovered the means of producing maximum arousal in the other. Though in the first instance the woman is advised to take a greater initiative in sexual activity, the man must respond reciprocally once roused; as confidence grows he is likely to assume the dominant role.

An example of a suggested sequence might be encouragement (a) to linger over pre-coital sex-play to increase the possibility of full arousal, (b) of the female to handle the penis (as directed by the man) sufficiently to induce and maintain a strong erection, and (c) to experiment and adopt different coital positions and techniques, etc.

In all these situations verbal and "physical" feedback from the male to the female—with regard to his level of arousal, the giving of stimulative instructions, and especially reciprocal caresses—are mandatory. Simultaneously he should express his appreciation of her selfless co-operation; this is a useful morale-booster and reinforcement to continue with her role in therapy.

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Sex Education

If indicated, appropriate sex education should be given to both partners jointly, who should be encouraged to ask any questions they choose. For example, it may be necessary to provide information relative to coital techniques, female sex anatomy, physiology, and psychology, and rectify false impressions resulting from misinformation derived during adolescence or later. A frequently encountered problem is that many people think that certain sexual practices are abnormal or perverted and therefore taboo. It should be emphasized to both that any type of stimulation which is mutually pleasurable and acceptable is perfectly "normal" and can be indulged without fear or guilt. In addition to encouragement to persevere with therapy and praise for any improvement, reassurance and support is necessary in most cases.

Premature Ejaculation

The most important component of treatment for premature ejaculation is extravaginal, manual stimulation of the penis by the woman. This should be provided in a continuous but undemanding manner to the male's direction when he is fully aroused and preferably non-anxious, and should be interrupted when he indicates that orgasm and ejaculation is imminent. When the feeling has faded away stimulation should be repeated until once again the sensation premonitory to ejaculation is reached, again being discontinued until the feeling dissipates. Ejaculation may thus be delayed for a considerable time. Once mastered, this procedure can be transferred to actual coitus; eventually some measure of ejaculatory retardation is possible in most cases.

The response to the first few treatment sessions may offer a guide to prognosis. Thus early improvement points to a completely satisfactory outcome, usually within 10 to 15 sessions. If, however, the condition has not changed by this time it is unlikely to improve later, even if therapy is continued over months or years. Recognition of this fact could perhaps save both patient and physician time and money; there is probably little justification for extending treatment beyond one year.

The type of disorder and its developmental characteristics are important in relation to the outcome of treatment. Premature ejaculators fall into two main subcategories: (a) those in whom the response has been habitual since adolescence, and (b) those in whom precipitancy developed after previous competency. Impotence can also be subdivided into acute onset and insidious onset types: the former develops suddenly, most often in young, normally sexed and responsive but naive and inexperienced subjects, often as an acute response to anxiety or other stress. On the other hand, insidious onset impotence is often associated with a progressive and relentless decline over months or years of sexual interests, activities, and performance; though anxiety may be prominent, it often may be the consequence of the impotence rather than its cause. These patients often seem unable to respond with an erection adequate for coitus to a type and intensity of sexual stimuli that formerly had been effective. This decline, which in some cases apparently begins in the late 20s or early 30s, is probably due to a combination of biological factors and psychological fatigue. This latter phenomenon, recognized by Kinsey and his co-workers, is probably due to repetition of the same sort of sexual stimulation and activities with the same partner over many years. In these patients measures to induce a sexual resurgence in an otherwise "flagging sex drive" by innovations like novel techniques, new types of stimulation etc., are important constituents of any therapy.

The best response occurs in those with acute onset impotence or premature ejaculation arising *de novo*. Failure of improvement within 5 to 10 sessions usually indicates complications, such as a personality disorder or severe neurotic

diathesis of one or both partners. In any event, at this point psychiatric intervention is indicated.

Impotentia ejaculandi and insidious onset impotence have a prognosis probably similar to, but less favourable than, that of the acute onset disorders. Nevertheless, some improvement or even complete restoration of potency can be expected in most patients, even if comparatively shortlived (lasting from one to three years).

In my experience people with habitual premature ejaculation generally have an unfavourable outcome. Possibly the judicious combination of phenothiazine drugs, such as thioridazine* and some form of relaxation technique may offer superior results to treatments in current use.

Another prognostic pointer is the time of onset of the disorder—"late onset" disorders, developing from previous sexual competence, have a better outcome than disorders which persist from the first coital attempt—"early onset disorders." This supports the finding that patients experienced in premarital coitus which was emotionally and physically satisfying more often respond better to treatment if at a later date they develop potency problems.

Though some authorities⁴ have shown them not to be absolute contra-indications to a successful outcome, increasing age (>40 years old) and a dysfunction of over two to three years augur a poorer prognosis. Increasing age is associated with a decline in virility; this tends to limit a response, even if the patient genuinely wished to be cured.

Sex Drive

There are many arguments concerning the genesis, nature, and even definition of male sex drive. Total number and consistency of sexual outlets to orgasm and ejaculation within a given time and the capacity to engage in repeated intercourse within a single limited period of sexual activity probably reflects sexual strength. Direction of sex drive, which refers to the nature of the preferred sexual object—namely heterosexual, autosexual, bestiossexual, etc.—is largely self explanatory and is less controversial. Nevertheless, sexual strength is not the vital prognostic pointer that it might be imagined to be. Provided there is a basic interest in heterosexual activities, subjects with a high strength do no better in therapy than those with a low one.

The direction of sex drive is of much greater consequence; the outcome of treatment is likely to be unfavourable unless the preferred sexual outlet is heterosexual coitus. The occasional exception to this is the patient who has a very powerful bisexually oriented drive, provided heterosexual coitus represents one of the preferred outlets.

Personality

The personality of the male or his female sexual partner, or both, may influence the therapeutic response decisively. Those with a personality disorder, for example—especially of an hysterical or a psychopathic type—do much worse than do subjects with integrated personalities. The former may be recognized by evaluating their interpersonal relationships, past and present. Manifestations such as egotistical attention-seeking behaviour, great hostility with acting-out tendencies and manipulation, a tendency to blame others for their own short-comings, a capacity for rationalization, and difficulties in communication all imply a person with a personality disorder. Supporting objective evidence such as educational,

* Some phenothiazine drugs have been seen to delay or inhibit ejaculation and orgasm "as an unexpected side-effect"; the underlying mechanism is not fully understood. At present this drug should not be used generally for this purpose.

military-service, and occupational instability may sometimes be obtained.

In such cases the disorder of potency may be merely symptomatic of a generalized incapacity to develop and sustain empathic and affectionate relationships with others. These patients should be referred for psychiatry, which is the treatment of choice. The state of the marriage as well as the feelings of both spouses are other aids to prognosis. Undoubtedly, an emotionally satisfactory marriage based on mutual feelings of affection augurs well for recovery.

Since the degree of motivation for cure must influence the outcome, an attempt to assess it should also be made. Generally, a patient strongly motivated for change will have referred himself, will want an improvement in his potency for its own sake and not to placate a frustrated spouse or to improve interpersonal relationships, etc., and will attend regularly for treatment. Poor or suspect motivation is suggested if the patient's referral is instigated by others, if he has other than a primary sexual reason for seeking help, and if he consistently fails to keep treatment appointments.

Conclusion

An admittedly oversimplified profile of the man with disordered potency is one who responds well to the sort of superficial, practically oriented therapy already described. He is likely to have referred himself or it will have been a mutual decision arising out of frank discussion between both partners.

He will be married and 30 years of age or under. He will have developed acute onset impotence or premature ejaculation in response to anxiety or other psychophysical stress, such as recent marriage, disappointments, physical illness, etc. He will have a positive emotional interest in sex generally and in heterosexual activities in particular; his potential to respond sexually may be evidenced by his continuing to masturbate successfully to orgasm and ejaculation, though his preferred outlet will be heterosexual coitus. He will have a good and affectionate relationship with his wife, who will be willing to co-operate fully in helping him to overcome his problem. Both will have pleasant, integrated personalities and be able to communicate frankly with each other; they will attend treatment sessions together and regularly.

On the other hand, the poor responder is likely to be at least 40 years old, with an insidious onset disorder of impotence or absent ejaculation which will have developed in the setting of a gradual but progressive decline in erotic interests and capacities over months or years. His referral will have been instigated by others, usually his wife. His relationship with her will be generally hostile and affectionless; one or both will have pronounced personality disorders; there will be considerable problems of communication. He will be erratic in his attendance for therapy.

REFERENCES

- 1 Johnson, J., *Journal of Psychosomatic Research*, 1965, **9**, 195.
- 2 Cooper, A. J., *British Journal of Psychiatry*, 1968, **114**, 719.
- 3 Cooper, A. J., *British Journal of Psychiatry*, 1969, **115**, 709.
- 4 Masters, W. H., and Johnson, V. E., Personal communication to be published in *Human Sexual Inadequacy*, 1970.

TODAY'S DRUGS

With the help of expert contributors we print in this section notes on drugs in current use.

Liquorice Derivatives

Medical folk-lore contains many references to the use of liquorice as an ingredient of mixtures for the treatment of dyspepsia. In the 17th century there was attributed to liquorice wood the action of "clearing the stomach" and "being good for an inflamed stomach." In 1948 Revers, in Holland, reported on the beneficial results of crude powdered liquorice extract given to patients suffering from peptic ulcer, but he found that oedema developed in about 20% of the patients. There have been many subsequent reports of liquorice eaters developing undesirable side-effects, such as hypertension, cardiac arrhythmia, hypokalaemia, and muscle weakness. Similar side-effects have been reported after the administration of pure glycyrrhetic acid, derived from liquorice. This is of great interest in view of the important studies which have been made in recent years of the place of liquorice derivatives in the treatment of patients with gastric ulceration.

Though there had been many publications in the European literature describing the value of liquorice in the treatment of peptic ulcer, it was not until 1962 that controlled clinical trials were carried out by Doll and his co-workers giving the first scientific proof of the benefits of a liquorice extract in the treatment of gastric ulcer.

Preparations Available

There are currently available two derivatives of liquorice which are of proved therapeutic value; these are carbenoxolone

sodium ("Biogastrone") and deglycyrrhizinized liquorice (in "Caved-S").

Sources of Liquorice Derivatives

The methods of preparation of the two substances are quite distinct. Carbenoxolone sodium is synthesized from glycyrrhetic acid, the aglycone of glycyrrhizic acid, one of the many constituents of liquorice root. The active principal of "Caved-S" is prepared from the residue remaining after glycyrrhizic acid has been removed from liquorice root. The resulting substance contains not more than 3% of glycyrrhizic acid, and would therefore not be expected to produce the metabolic effects of glycyrrhetic acid.

Pharmacology

Carbenoxolone sodium.—When given parenterally carbenoxolone has anti-inflammatory activity which is at least in part dependent on endogenous production of adrenocortical steroids. There is little evidence of glucocorticoid activity. The effects of carbenoxolone on electrolyte balance resemble those of aldosterone. Retention of sodium chloride and water may occur with a corresponding increase in the volume of extra-