

international  
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## IMPOTENCE AND SEXUAL DYSFUNCTION

Impotence is a type of sexual dysfunction that is associated with problems maintaining an erection, ejaculating or reaching orgasm. The term traditionally implies that a man is unable to achieve an erect penis. Impotence also connotes that a man who does not have an erect penis is considered weak or feeble. The term 'impotence' has been largely replaced with 'erectile dysfunction' or 'sexual dysfunction' when referring to a person's physical body. 'Impotence' remains, however, a loaded word in terms of defining men and masculinity; it refers to a man who lacks political power and, by inference, also lacks sexual power.

'Sexual dysfunction' is a broad term that encompasses problems relating to a person's sexual performance. It describes the various ways in which a person is not able to experience and perform desire – in a man's case, through erection, ejaculation and orgasm. As such, sexual dysfunction connotes a medical condition, defined as the inability to achieve an erection that is adequate for satisfactory sexual performance. This broader medical descriptor moves impotence under the medical heading of sexual dysfunction. Importantly, this linguistic turn shifts responsibility for a flaccid penis away from the man and places fault with the organ – now called the 'dysfunctional' organ. Nevertheless, sexual dysfunction may be evidence of a man's emotional well-being, his physical health, his relationships with a partner, or even with the culture at large (Bordo 1999).

Sexual dysfunction, also called erectile dysfunction, is often the result of illness or aging. Sexual dysfunction may be caused by a number of physiological and psychological conditions. Physiological antecedents include diabetes, depression, prostate cancer, spinal cord injury, multiple sclerosis, arteriosclerosis and heart disease. Injuries to the penis that cause nerve, tissue or vascular damage can also trigger sexual dysfunction. It is also a

common side effect of some prescription medications, including antihistamines, antidepressants, antihypertensives, antipsychotics, beta blockers, diuretics and tranquillisers. Psychological antecedents include sexual performance anxiety, stress and relationship difficulties.

Since its publication, Masters and Johnson's *Human Sexual Inadequacy* (1970) has served as the prototype for research done in the area. This work was influential in moving the discourse of sexual relations from relationships to sexual physiology. The categories of sexual dysfunction defined by Masters and Johnson were subsequently included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; APA 1987) and are now considered 'mental disorders' that can be measured and treated. In the context of the DSM, sexual dysfunction is defined exclusively in terms of heterosexual sex – the inability to reach orgasm in a vagina (APA 1987) – and thus also represents a major area of critique for its heterosexist assumptions.

At one time, psychotherapy and sex therapy were considered the only ways in which men could treat sexual dysfunction. However, the use of physiological and psychological measures, such as the International Index of Erectile Function (IIEF; Rosen 1997), shifted the way in which sexual dysfunction was assessed and treated. Brief assessments, like the IIEF, ushered in a new model of sexual health for men that emphasised medical treatment of sexual dysfunction over psychological interventions. These have mainly included pharmaceutical options, including phentolamine which causes blood vessels to expand, thereby increasing blood flow, which results in an erection, and sildenafil citrate (sold under various brand names, such as Viagra and Cialis), a vasodilator that dilates the blood vessels. These medications work through improving blood circulation to the penis, which relaxes the smooth muscle of the penis and regulates blood vessels during sexual stimulation, allowing the penis to become engorged, leading to an erection.

The present-day implications of this medical model are that sexual dysfunction is now treated solely as a problem concerning the lack of adequate blood flow to the penis. Critics argue (Tiefer 2004) that physicians' use of diagnostic tools regarding sexual dysfunction reduces a man's sexual health to whether or not he has a functioning penis and that other layers of his health – both physical and psychological – are overlooked in order to treat the 'dysfunctional' organ. This perspective states that without attention to the relationship in which the sex occurs, medications may produce erections, but a discussion of pleasure for either partner remains silent and therefore remains untreated.

No doubt, developments in the late twentieth century concerning the diagnosis and treatment of sexual dysfunction have allowed more men to speak more openly about health issues that affect their sexuality, thereby combating stigma. However, all of the talk about the male anatomy, not to mention 'four-hour erections', has created a host of new expectations and normativising pressures on erect men and their partners. First, the 'Viagra phenomenon' often assumes a model of sexuality in which intercourse is the only method of appropriate sexual activity. Second, the resultant definition of sexual dysfunction emphasises functionality irrespective of pleasure. It is essential to keep sexual desire as a component of how functioning is imagined, discussed and sought. If sexual desire is the sum of the forces that lean us towards and away from sexual behaviour, then it is essential for sexual function to be defined in terms of this sum of desires, not merely the desire to adequately penetrate another person.

### References and further reading

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**See also:** male sex drive; penetration; penis; sex; sexuality; Viagra; virility

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### INDIAN MASCULINITIES

'Indian masculinities' are the concomitant of the varied histories of the pre-colonial, colonial and post-colonial eras, and caste and religious identities. A key theme during colonialism concerns the 'masculinisation' of European identity, and the 'feminisation' of its native counterpart. However, while some natives were feminised, others – such as Sikhs and Gurkhas – were declared to be 'martial races' (Omishi 1991). This concept was particularly deployed in the aftermath of the 1857 mutiny in light of the subsequent reorganisation of the Indian army. Concurrently, there emerged the figure of the effeminate Indian, of whom the educated Bengali (Sinha 1995) was only the best known of a number of such stereotypes. However, this does not imply that the British simply 'invented' certain types of masculine cultures and imposed them upon Indian culture. 'Martial masculinity' (O'Hanlon 1997) was also an important aspect of *pre-colonial* life, one which the colonisers built upon and incorporated into the discourses of colonial masculinity.

The colonial period also witnessed a stigmatisation of non-heterosexual masculinity. Section 377 of the Indian Penal Code, prohibiting 'unnatural sex', was enacted in 1861 and continues to be law in contemporary India. The relative lack of censure regarding (male) homosexual relationships that characterised the pre-colonial period eventually gave way to the *public* and legal heteronormativity that