

1969

## Modern look at impotence

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A MODERN LOOK AT  
IMPOTENCE

By  
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August 1, 1968

Class of 1969

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## INTRODUCTION

Although the material within this paper is most concerned with the subject of impotence in the male, mention shall be made of its closest counterpart in the female -- frigidity. Definitions of the two subjects thereof will be included in the next and initial portion of the paper. As shall be made clear, impotence is an entity which is more easily diagnosed and defined and is probably more prevalent because of a greater variety of etiologic factors involved. As one might preclude, frigidity will not therefore be a secondary result to various medical insults that predispose impotence. Such cases of impotence will be included under the topics chemical and organic impotence.

## BIBLIOGRAPHICAL NOTE

At various points throughout this thesis the foot-notation (1A) will follow text material. As noted in the bibliography, (1A) refers to either direct quotes or paraphrasals from an interview with Dr. William H. Masters. The interview was conducted by myself in Dr. Masters' office in St. Louis on July 13, 1968. For the most part the topics discussed in the course of this interview were impotence and frigidity.

Multiple illustrations including case histories will be quoted to support examples within the general text of this paper.

## DEFINITIONS

At this time the subjects of this paper shall be defined:

"Frigidity - A loosely applied term used to express female sexual inadequacy ranging from the freudian concept ( inability to achieve orgasm through coition ) to any level of sexual response considered to be unsatisfactory by either the individual female or her partner on any particular occasion." (1)

"Impotence - Disturbance of sexual function in the male that precludes satisfactory coitus. It varies from inability to attain or maintain full erection to total loss of erectile prowess. Primary impotence: difficulty from the onset of sexual activities. Secondary impotence: difficulty which arises later in life, following a history of effective sexual functioning." (1)

" Frigid - Abnormally averse to sexual intercourse.

Impotent - Unable to copulate." (13)

"Frigidity - That condition wherein the female is unable to initiate or maintain the heterosexual arousal pattern." (2)

"Impotence - That condition wherein the male cannot obtain or maintain penile erection satisfactory to him for purposes of heterosexual coitus." (2)

The latter definition excludes the phenomenon of inability to erect or maintain erection during the homosexual act. This does occur and it would seem logical to include it or, more specifically (with respect to the above), not to exclude it from any definition of impotence.

One sees immediately the diversity in definition of this terminology, especially with respect to frigidity.

Defining impotence is an easier task because of its anatomical considerations. Erection is a process which can be observed objectively by the patient, sex partner, or researcher. This is not to say, however, that the female orgasm is not a clear-cut entity also. Most, if not all women, according to Masters, can state definitely that they do or do not achieve orgasm during sexual activity. It must be clear though, that in spite of recent work in this area, there is still a lack (outside the research laboratory) of objective, overt, and gross anatomic deficits concomitant with frigidity and easily observable by the mate. After distilling out the many descriptions of impotence, it is clearly seen to be a phenomenon which is directly proportional to the inability to erect.

Frigidity, on the other hand, is a more nebulous term. The preceding Webster's definition seems to be most popular among laymen.

"In attempting a definition of frigidity one first meets a long-standing controversy: clitoral versus vaginal orgasm." (2)

As outlined by Hastings, one school of thought maintains the clitoris as the sensitivity organ during childhood and adolescence while the vagina maintains this role in the mature woman. According to this freudian concept, if the transfer (from clitoris to vagina) of sensitivity does not take place, the woman is neurotically frigid. Psychoanalytic approaches to solving this problem have therefore evolved.

Masters, in discussion of the clitoris, clearly denies, however, the existence of vaginal and clitoral orgasms as separate entities. This is based on the anatomic consideration that the pelvic viscera responds no differently to stimulation of various organ sources. More specifically, during intercourse the clitoris receives its stimulation not by direct contact with the penis but by a secondary pull by the stretching vagina via the clitoral hood. (1A),(1)

By their very nature, impotence and frigidity are often first seen by the practitioner through the complaining partner of the frigid wife or impotent husband. While both problems evoke frustrations and share other similarities and counterparts, they shall be treated separately herein, with the greater emphasis on impotence.



## IMPOTENCE, CLASSIFICATION

In pursuing a study of impotence, a classification of the subject is found helpful. Hastings (2) has devised the following useful system:

- I. Etiology
  - A. Due to chemicals
  - B. Due to organic disease
    - 1. Systemic
    - 2. Local
  - C. Due to psychological factors
- II. Time in Sexual Pattern
  - A. Arousal (Specify time)
  - B. Genital union ( Specify time )
- III. Specificity
  - A. Absolute (no erection under any circumstances)
  - B. Selective (Specify)
- IV. Duration of Expected Duration
  - A. Acute (and probably constant)
  - B. Chronic (and probably permanent)

This is a quite descriptive classification in that it summarizes in brief the history, etiology, and nature of the problem.

A less specific, commonly used classification is, of course,

primary and secondary impotence. For the most part, primary impotence is inclusive of chemical and organic types, while secondary impotence includes the psychological types. Secondary impotence is by far the greater in incidence, being four to five times as high in prevalence. (1A)

## CHEMICAL IMPOTENCE

"The chemicals involved in impotence are primarily drugs, mainly of a sedative or narcotic type." (2)

Often included in the listed side effects of commonly used sedatives, hypnotics, anticholinergics, and tranquilizers is the warning of possible impotence. Acute transient impotence has long been associated with excessive alcoholic intake while a more chronic form is found frequently in morphine addicts according to Goodman and Gilman. (4)

It is unique that while clearly alcohol can cause acute primary impotence, it may also be causative in chronic secondary impotence.

"Secondary impotence in middle-aged males is associated with a higher incidence of excessive alcoholic consumption than any other factor." (1)

"The incidence of secondary psychological impotence increases with the duration and intensity of the alcoholism, despite the fact that the patient may have regarded alcohol as a coital aid early in his illness." (5)

Gallant goes further to state that "Most alleged aphrodisiacs are likely to produce the opposite effect."

He brings out the occurrence pattern of the alcoholic patient pursuing another (extramarital) partner in an attempt

to ameliorate the situation. If though his drinking increases in association with his new mistress, he may again fall back into his pattern of impotence. Gallant goes on to recommend that the patient and the spouse presenting with this problem often require psychiatric help under a program of one therapist for the couple. This, he says avoids distortions and misunderstandings between the pair which may become magnified with separate therapists.

Even cigarette smoking has been implicated as an etiologic factor according to Hirschfeld. (3)

Treatment of chemical impotence would logically appear to consist of removal of the offending agent. Obviously, when dealing with such agents as alcohol and morphine derivatives one should investigate further as to the initial factors prompting the patient to use such products. Perhaps these initial factors are also the primary cause of the impotence or perhaps the impotence, itself, is the initial factor involved in prompting the use of the agents. Also existent will be those cases in which drugs are being used to treat another related or unrelated disease process. Medical judgement and knowledge of alternative pharmacology will be helpful in these circumstances.

## ORGANIC IMPOTENCE

As noted in the previous outline, local and systemic organic types of impotence may exist. The following is a short list of disorders or conditions which may associate themselves with impotence.

1. Diabetes mellitus (uncontrolled) (6)
2. Malnutrition and/or vitamin deficiencies (6)
3. Myxedema (6)
4. Mumps and other diseases resulting in physiological castration
5. Prostate disease resulting in pain (2)
6. Post prostatectomy status (9)
7. Tabes dorsalis (10)
8. Transections and lesions of the spinal cord, cauda equina, and peripheral nerves (2)
9. Lesions of the basal ganglia (12)
10. Age (8)
11. Psychoses (1A)
12. Neuroses (1A)
13. Alcohol (1A)

Although probably not demonstrable by tabulated statistics, general malaise secondary to an infinite disease variety certainly causes temporary impotence. Probably every man in existence, who has suffered even a severe cold, has experienced a simultaneous related impotence.

It is well to note as Hastings cites, that whereas transient impotence may associate itself with sickness, chronic impotence may result from chronic illness. This, in contrast, is likely to be a problem of such proportion that it may require as much consideration as the primary disease process itself.

It is well accepted that testosterone deficiencies secondary to a variety of testicular insults can result in impotence.

" The presence of impotence, not of psychiatric origin in a male with a perfectly adequate sex history prior to his complaint, may be associated with a definite decrease in size of his testes, a low 17-ketosteroid level, and a high FSH level." (7)

Kupperman draws on this by suggesting that a "medical therapeutic" approach would be fruitless in absence of change of testicular size, low steroid level, and /or high FSH levels.

I would draw from this further, that a complete physical examination of the external male genitalia with careful serial measurement of testicular size should be done in the initial screening of impotent patients and that a carefully taken concomitant history of associable disease be compiled.

Findings therein may indicate FSH assays and assessment of steroid levels be taken (tests which might be too expensive as routine screening).

Kupperman also associates the above findings with the nebulous diagnosis of male climacteric, which he defines as "a rather evanescent syndrome characterized clinically by increased nervousness, vasomotor symptoms, irritability, irascibility, inability to concentrate and think logically."

He also suggests usage of placebo trials so as to rule out psychosomatic etiological factors.

Simpson's writings report return of potency after castration and subsequent treatment with testosterone regardless of the castrating agent.

In using androgenic steroids therapeutically, Kupperman cautions of the danger of enhancing growth of prostatic neoplasms.

Also a must to consider with respect to castration is Hastings' view that "The complexity of human sexual response is no place better seen than in a review of the literature on castration, whether the castration be purposeful, traumatic, or the result of disease. It is obvious that castration, particularly in the adult, may induce psychological factors productive of impotence that have little or nothing to do with endocrine changes."

One may assume, after distilling out the literature, that there is not necessarily a direct cause and effect relationship between castration and impotence. In spite of

this, one cannot ignore the overwhelming usage of replacement testosterone therapy and subsequent cures.

Other endocrinopathies have strongly implicated themselves as causative factors in impotence as well. According to Kinsey (8) diabetics have at least twice the chance of becoming impotent than non-diabetics.

McDowell (12) reiterates the high frequency of sexual disturbances associated with diabetes. He attributes this to the neuropathologic process of peripheral parasympathetic and sympathetic nerves. More specifically, he points out that large afferent components of the reflex arcs (to the external genitalia) needed in sexual functions are interrupted. Very interestingly, he also reports that the loss of libido is preceded by impotence indicating a peripheral rather than central origin.

Simpson indicates that the high incidence of impotence is found among the uncontrolled diabetics only.

Myxedema as mentioned previously may also, according to Simpson, be causative of impotence. After a moderate review of the literature on myxedema, I find this mentioned infrequently and therefore assume this to be rare.

Much appears to have been written on the effects of prostate disease and prostate surgery on the sexual response.

"There appears to be agreement that prostate disease per se, whether it be infectious in nature or due to a benign or malignant tumor, does not result predictably in any interference with the sex drive or potency unless the



lesion is such that it produces pain. In this regard it can be interfering." (2)

According to Finkle "the psychological impact of inquiring about potency or prostatic surgery or both could in itself seriously influence sexual potency after prostatectomy." (9)

This should be kept in mind when reading anyone's literature and statistics on the complications or side effects of prostatectomy. In general though, Finkle maintains that potency is usually retained after prostatectomy. He suggests though that with respect to medicolegal implications, a person should be advised of possible altered potency such as "dry ejaculation" which may occur following prostatectomy.

My rather limited personal experience on a urology ward indicates that patients often blame their impotence on previous prostatic surgery. When one considers the mean age of such patients, however, it would seem reasonable to consider that other factors, eg. age itself, atherosclerosis, psychiatric disorders associated with age, or chronic brain syndromes are being brought into play in the problem. I can recall the situation of an eighty-year-old man refusing a transureteral resection because of the "probable" resulting impotence.

While as pointed out by Kinsey (8), impotence and lack of sexual activity increase with age, one must approach each patient in a subtle and tactful manner realizing that:

1. Indeed many elderly men are sexually active and
2. That what is said to the patient preoperatively may affect him postoperatively as noted before.

The following is Finkle's summary of factors determining postoperative potency:

- "1. Age alone does not preclude sexual performance before or after prostatectomy. There seems to be a generally progressive decline after the age of 70 years, but there are notable exceptions.
2. Availability of a willing and able sexual partner is the most important consideration in continuing sexual activity before and after prostatectomy.
3. Factors other than the operation itself influenced preservation of potency. These included a desire to be free of "marital obligation" of intercourse, groundless fears that intercourse would aggravate cardiac or other (even minor) disabilities, preference for alcoholic or other diversions, and reluctance to seek sexual outlet in the face of a disapproval by a wife, grown children or even neighbors.
4. Attitude and comment of the physician can play a significant role in encouraging or stifling the patient's interest in continued sexual activity after prostatectomy.
5. For the most part, psychological factors dominated the continuation of sexual function, preoperatively

as well as postoperatively." (9)

Finkle goes on to say that the majority of 200 patients studied retained potency regardless of the surgical approach. Final figures of the retained potency are as follows:

Finkle	87%	(all approaches)
Lilien (11)	60%	(suprapubic)
	28%	(perineal)

In tabes dorsalis (locomotor ataxia), according to Heyman, "Impotence and loss of sexual desire are frequently noted." (10) In this disease one might assume the impotent component to be a result of the degenerated posterior spinal nerve roots, however, this would certainly not account for the loss of sexual drive noted concomitantly. Perhaps one could argue that the impotence is only secondary to the loss of drive and not dependent on the nerve degeneration. It is probably most reasonable to concede that the impotence is a result of not only nerve damage and/or loss of sex drives, but also the often accompanying demented psychosis of syphilis.

As in diabetes, McDowell states that in tabes peripheral afferent neuropathy is the pathophysiology of impotence as well as disruption of bladder and bowel dysfunction.

Other neuropathologic conditions involving the parasympathetic nerve supply to the penis or more proximal nervous entities can also cause impotence. Cord transections, in spite of being above sacral parasympathetic reflex arcs, may be a partial contributor to impotence by interrupting

the mode of psychic stimulation. However, as cited by Hastings, men with cord transections, though handicapped by mobility problems, are able to achieve coitus because of the intact parasympathetic reflex arcs. He goes on to exclude neurologic damage as a sole cause in absence of other (aside from impotence) defects.

"It is difficult to conceive of a neurological lesion which produces only impotence and no other signs or symptoms. In the absence of other signs or symptoms, the diagnosis of organic impotence, due to a neurologic lesion, is untenable." (2)

More proximal central nervous system disturbances, eg. cerebral cortex and basal ganglia, have also been implicated in altered sexual function.

"Neuropathies caused by a deficiency of thiamine, vitamin B<sub>12</sub>, or nicotinic acid are often associated with decreased libido and impotence. It is not always clear whether the impotence is due to peripheral neural or central neural involvement or to general debility, since the neural disturbances in nutritional deficiencies are generalized." (12)

Along the line of neurologic pathology one is often concerned with sexual effect of sympathectomy (a procedure less commonly done today than in the past). While according to McDowell, retrograde ejaculation may result here from a paralyzed internal bladder sphincter, the erection process is unaffected.

Sexual functional changes also occur with respect to pituitary pathology.

"Loss of libido is a very frequent complaint of patients with pituitary tumors." (12) McDowell goes on to say, however, that this may be a hormonal dependent and not a neurologically dependent phenomenon.

Finally the subject of neuropathologically produced sex functional alterations is well summarized by McDowell:

"Most neurologic disturbances produce hyposexuality more often than an increase in sexual activity. Disease of the peripheral nervous system and spinal cord usually produces impotence with retention of libido. Disease of the central nervous system, cerebral hemispheres, brain stem, and basal nuclei tends to cause loss of libido before loss of potency.

Sexual dysfunction may be a very early manifestation of nervous system disease. Complaints of loss of potency and libido in men and loss of libido in women should prompt a thorough neurologic examination."

Atherosclerosis with its local and central nervous system effects is often blamed for impotence, but according to Masters (1A), this accounts for probably less than seven percent of all impotence. The atherosclerotic process seems to have become a wastebasket classification for incompletely investigated cases according to my experience. I would assume from this that the incidence is even less than the stated seven percent.

Another commonly accepted cause of impotence takes into consideration circumcision.

"This concept was founded upon the wide spread misconception that the circumcised penile glans is more sensitive to exteroceptive stimuli of coition or masturbation than is the glans protected by a residual foreskin." (1) From this it is assumed that a lack of ejaculatory control inclines the circumcised male toward impotence. Via exteroceptive and light tactile discrimination studies, Masters and Johnson, however, have established that no significant difference is found.

The treatment of the various types of organic impotence cited are specific as to organic cause. It is beyond the scope of this paper to discuss in any depth the control of diabetes, tabes dorsalis, etcetera for reasons which are obvious. It should be directly obvious to the reader as to which of the listed etiologic entities are reversable and which are not.

## PSYCHOLOGIC IMPOTENCE

Because impotence as an entity is more accurately studied from the aspect of being a symptom\* of other disease processes it hardly needs to be said that multiple processes often interplay in vicious cycles to cause and aggravate impotence. As an example, Masters (1A) says there is a 300% higher incidence of secondary impotence associated with diabetes than in the remainder of the population, although the diabetes may be acting merely as a trigger mechanism.

The altered (diabetic) sexual response thus triggers a development of fears of performance while the patient fails progressively. The impotence can therefore have perhaps a major component of mental process in addition to the diabetic process. Obviously it is presently impossible to quantitatively determine which process contributes more to the problem.

From this it can be logically reasoned that in any of the previously discussed causes of impotence, psychologic harmonic overtones may serve to finish the impotent symphonette.

\*symptom - Exceptions will be cited later.

Notation will be made at this point, that the topic of premature ejaculation is not included in this paper. As per the definitions appearing at the beginning of this paper it is vividly shown that the phenomenon is not a form of impotence. It is mentioned, however, only because there exists a "similarity in their therapeutic approaches." (14)

This portion of the paper will serve to discuss in greater detail the impotent male whose ultimate problems are indeed directly concerned with his psyche. Such problems resulting in impotence will be thusly included in this section and will be arbitrarily defined (by their inclusion) as psychological impotence. Also partially included under the definition of psychological impotence are:

"Inadequate erection - Full penile erection either cannot be achieved or, if accomplished, is maintained fleetingly and lost, usually without ejaculation.

Non emissive erection - Full penile erection is achieved, but ejaculation cannot be accomplished with the penis contained within the vagina." (14)

The foremost characteristic of psychological impotence is so obvious that it may be overlooked in the patient's initial workup. This characteristic is selectivity and according to Hastings, is pathognomonic, not being present in the chemical and organic impotent types.

"The characteristic symptom of psychological impotence



is that it is selective in nature, ie., occurs under one set of circumstances but not under another." (2)

Hastings goes on to cite the following examples of when this "selective" impotence occurs:

1. with wife only
2. with mistress only
3. with women of equal social rank only
4. with women only
5. in the morning only
6. combinations of the above

Hastings also discounts the myth that morning erections are secondary to bladder distention. Along this same line of thinking, he brings out indirectly that this can be a good prognostic and diagnostic sign.

This is reasoned from the fact that presence of the morning erection proves the erectile apparatus to be intact.

Hastings provides the following useful list of questions to be asked of the impotent patient:

- "1. Do you have erections in the morning?
2. Do you have erections with dreams?
3. Do you have erections with masturbation?
4. Do you have erections during sexual daydreams or fantasies?
5. What is your performance with sexual partners other than your wife (if applicable)?
6. Do you have erections under any other circumstances?" (2)

Impotence only with the wife may have multiple causes according to Hastings. He states, however, that most commonly it stems from hostile feelings of a passive husband toward his wife. In this situation the husband welcomes an illness or other based excuse for his impotence, for example prostate trouble, fatigue, etcetera. Hastings continues that the husband may bring this matter to the physician's attention to obtain a justification which will serve as a powerful weapon against the wife.

"Withholding of sexual contacts is a frequent hostile act in a disrupted marriage. It is a particularly powerful weapon against the husband or wife who has relatively high sexual drives and equally high moral or ethical bars to extramarital contacts, masturbation, or other sexual outlets." (2)

Impotence with one's wife, or more generally, impotence with a loved female is relatively common says Hastings. In this situation the man is impotent only with the woman with whom he is affectionately involved. Hastings cites that this was described in 1912 by Freud and that an analytic approach in etiology reveals a defect in the sexual maturation process.

"If newer sensual feelings become attached to incestuous fantasies, the result is total impotence. In other words, male sexual maturity requires that the older affectionate (love) feelings be freed from the (forbidden) mother and fused with the newer sensual feelings and that both then

attached to the loved object (wife)." (2)

Hastings' experience indicates, as one would suspect, that the wife is inclined to blame herself, that a vicious cycle is thus commenced, and that psychiatric help is then in order.

As mentioned earlier, alcohol is often implicated by itself or in association with other agents as a cause of impotence. Masters cites a good example of what he terms a typical episode for the onset of impotence. Much can be learned from this illustration, which can be thought of as typical in the context of our present-day society. It focuses a unique light on the subject which no longer allows the reader to think of it as only a symptom of an underlying disease process, psychological or otherwise.

"Mr. and Mrs. Smith go out on a Saturday night. He has entirely too much to drink. She has to drive him home. She flounces onto the bed and he staggers around downstairs hunting for a nightcap or two that he obviously needs like a hole in the head. And then he crawls up the stairs, goes into the bedroom, and jumps in bed and nothing happens.

On Sunday he worries about this and is not sure everything went well last night. He can't ask his wife because she is not speaking to him. He goes to work Monday and thinks about it on the way to work. He then thinks that night, he'll check it out but something happens. He thinks it's been a long weekend and therefore he'll wait till

tomorrow." (1A)

This illustration can be of major consequence to the practitioner when it is focused to reveal a first major point:

"If you'll take a careful history, you'll find that it is very rare that if a male fails (this is an acute episode of failure) that he gathers his courage in less than 72 hours to try it again." (1A)

Masters finishes the above illustration describing Mr. Smith on Tuesday spending much more time ruminating the problem and even stopping for a few drinks on the way home, to calm his nerves. His arrival at home is the scene of a reconciliation with more drinking and he fails a second time.

"From then on he's got his fear of failure, his fear of performance, his fear of non-performance, if you will." (1A)

A second significant point by Masters has now been illustrated which is that, whereas, initially no basic psychopathology existed, Mr. Smith has created his own and can therefore become a neurotic even though he was not initially predisposed in this direction.

In reanalyzing this information, can we continue to say that impotence is always a symptom of some underlying process, whether it be organic or psychogenic? In the above illustration the answer peering through is an unequivocal "No!". So it can therefore be demonstrated that the impotence (in some cases) is the initial pathogenic agent contributing to

the situation, which in general would be best described as psychogenic, secondary, etcetera.

### Religious Factors

Putting impotence back into a role of disease symptom, we find that its presence may indicate the very common primary disorder of "frustrating religious hangups". It is my opinion that various kinds of religious beliefs often provide a core around which extensive psychopathology may be conveniently built. The following illustration is described by its reporter as a "classic story".

"A man came in who was a staunch Catholic, who went through college, had some manner of dating experience, a little premature ejaculation, but never tried to mount. Immediately after college he went into a monastery, where he was for about 20 years. He is now separated from his order, and his first exposure to heterosexual environment, in his mid-forties, marks the onset of total impotence." (1A)

Perhaps a more commonly occurring history is that of the woman manufacturing tremendous anxieties over her use of contraceptive devices in the shadow of church bans. Though this paper is not immediately concerned with sexual problems in the female, it is well to note, a counterpart problem with similar etiology.

Limited personal experience recalls that an overwhelming percentage of a small group of neurotic Catholic patients, on oral contraceptives, admittedly have related

anxieties to a marked degree. One woman, in particular, stated that she had to discontinue use of the medication because of her excessive anxieties ( with respect to the pill ) felt while in church. It would seem only logical that such patients be either reoriented by a more liberal member of their clergy (preferably) or disoriented from the church by a physician in an attempt to vent such anxieties.

With respect to the pill, it is well to point out that according to Masters (1A), a woman may become non-orgasmic after a period of 18 months of usage. This applies especially to the newer one milligram types. It is assumed that this is a result of the woman being maintained on steroid levels which are lower than those supplied by the unsuppressed ovaries.

#### Impotence of Inexperience

Another type of psychological impotence is "impotence of inexperience."

"A situation based on inexperience which produces acute anxiety bordering on panic: when a young man makes his first attempt to have sexual relations, finds that he cannot get an erection, and is flooded with overwhelming anxiety." (15)

Pursuing further, Hastings describes the patient having gone through a struggle of masturbation anxiety, in his adolescence. A resulting fear of damaged genitalia contributes. If the boy then experiences impotence, due to

inexperience, he is then convinced of the damage says Hastings.

He goes on to say that this may occur on the honeymoon, but impotence due to inexperience, at any time, is rare.

#### Familial Influence

Finally, familial influence is seen to be a significant factor in the development of impotence and frigidity.

Masters (1A) states that the mother usually has the most influence on her son, but that she may also ruin her daughter's chances for orgasmic return by, for example, telling her how dirty sex is, etcetera.

Familial factors, predisposing to homosexuality, could seemingly, also, alter the heterosexual response so as to effect performance. Bieber implicates here, the intimate mother and the hostile father as the major causative factors.

"Homosexuals are biologically normal males. Recent studies, indicate that homosexuality is a condition patterned within the family." (16)

#### The Small Penis

A "problem" related to impotence is the male who is concerned with his apparently undersized penis. This entity, is the concern of many men and is unfortunately being "treated" by many physicians. It stems from the all but obsolete phallic fable that virility is directly proportional to penis size. Even more unfortunate is the fact

that the penis size is often judged in the flaccid state. Added to this is the ultimate of misfortunes, in this instance, that being that the judgement of size is made frequently by a friend in the locker room at high school or the fraternity at college. The judging friend, having doubts about his own virility, may delight in projecting his own problem.

According to Masters and Johnson (1), (1A) the smaller flaccid penis proportionately undergoes more extensive enlargement during the erective process so that the end result may be slightly, if at all, different.

Furthermore, Masters (1A) goes on to say that the vagina, through a receptive relaxation process, accommodates and/or compensates for penile size variation so as to provide for similar fit. This process of receptive relaxation is involuntary and therefore not unlike the reflex muscle tone mechanism used by the bladder to accommodate for changing quantities of urine.

From this it is clear that, with the exception of extreme cases, exteroceptive sensation on the part of the female should be the same for a variety of penile sizes.

Not only does this remove most of the basis for the phallic fantasy, but it indicates that many men are being treated for a problem which, tragically, they do not have.

In stating that "most of the basis" (in the previous sentence) is removed, I have left open the possibility of additional psychic stimulation to the female upon seeing a large erected penis as opposed to a not so large and less impressive erected penis.



## TREATMENT OF PSYCHOLOGICAL IMPOTENCE

Any review of the literature reveals almost a complete vacuum of specific material on the treatment of psychological impotence. There exists even a stronger vacuum of material on follow-up studies of previous therapeutic trials.

This, the final major portion of this paper concerned with treatment of psychological impotence, is therefore short and incomplete.

Masters (1A) begins his concept of treatment by stating that "there is no such thing as an uninvolved partner in a marriage where there is sexual inadequacy."

For this reason both members of the marital unit are reoriented or "treated".

"I think the great difficulty in the past has been that one has tried to work with the impotent male or frigid female but rarely with the marital unit, so that you work with an impotent male and even reverse him here, send him back to a wife who has not been oriented, who has not been educated, who doesn't know what's wrong, and you're sending him back, not infrequently, to an environment that castrated him to start with." (1A)

Masters' and Johnson's work is done on a daily basis with the objective of reversing the symptoms in a two-week period.

He considers the therapeutic attempt a statistical failure if the couple cannot be reoriented with a reversal of symptoms in the two-week acute treatment period. A cure rate of 300% better than published before is claimed. Beginning in January, 1959, Masters and Johnson began the clinical phase of their work, which includes five-year follow-up.\* The majority of follow-up is done via interval telephone checks following the acute phase of treatment. The telephone checks start at two, four, and eight-week intervals as long as the new status quo (reversed symptoms) is maintained. At five years a complete re-evaluation is done to finalize the case. The resulting statistics of their work thus consists of:

1. treatment failure rate (in the acute treatment phase)
2. long-range effectiveness after successful, initial treatment.

One final note concerning treatment will be made about artificial appliances.

Many physicians, perimedical personel, and even lay people have received advertising literature via the U.S. Mail promoting artificial penises and vaginas, as well as rectal stimulators and other related devices. After reviewing much of this advertising material personally, I would conclude that the only purpose for which the devices were sincerely designed, is to profit the manufacturer.

\*follow-up - In 1970 Masters and Johnson are to publish the results of their follow-up studies.

It would seem that the use of an artificial penis by a frustrated impotent male would serve to further frustrate him and remove any incentive for a sound cure.

This also brings to mind topical anesthetic ointments, usually sold in the filthier of service station bathrooms (via vending machines) around the country. Such preparations, when applied to the penis, are "guaranteed" to "cure" premature ejaculation while making the male more virile generally. Such an approach would be tragic in view of the present-day cure rates of premature ejaculation after treatment.

Masters' (1A) only comments about such devices are that he has never used them in treatment and that they are not necessary.

Masters (1A) summarizes his treatment conditions approximately as follows:

1. One must go on the assumption that there is no such thing as an uninvolved partner.
2. Therapy should be done by dual-sexed teams.
3. Symptoms can be reversed in a two-week period presuming the couples are seen seven days a week. In this way, if a problem comes up, it will not be allowed to increase with respect to the time factor.

It is well known that impotence as well as frigidity may associate itself with various neuroses and psychoses. When possible, the former are treated as entities of secondary impotence. Psychoses are of course another matter.

Masters (1A) says that he accepts only referred patients and, in so doing, automatically screens out the psychotic.

The psychotic patient with impotence would probably be less concerned with the impotent component of his problem anyway. Severe depressions, which would accompany some psychoses (especially the involuntional psychotic), could be expected to associate with impotence frequently. One also must appreciate that impotentogenic tranquilizers and hypnotics, often used to treat the psychotic, must take precedence even if it means a compromise of sexual adequacy.

## SUMMARY

Little emphasis has been placed on the older, partially outmoded, developmental theories of impotence. I have tried to present a modern overview of the subject after defining and classifying it. With few exceptions, I have cited only very recent bibliographical material and have attempted to update this material even further with the often referred to interview with Dr. Masters.

The formerly forbidden field of sexology has now become "appropriate" for scientific study reflected by an ever increasing new interest in research and current publication. The sub-specialty of sexology, however, whether it be a branch of medicine, psychiatry, gynecology, or urology, has not yet been defined nor has there been set up, to date, such a clear-cut program of study. For this reason I feel that papers, books, and current periodic publications (eg. Medical Aspects of Human Sexuality) will have to, at least temporarily, serve as a source of knowledge so that physicians may "teach themselves" the principles in management of the sexual problems of their patients.

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