THE PRESENTATION AND DIAGNOSIS OF IMPOTENCE IN GENERAL PRACTICE

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There be three things which are too wonderful for me, yea, four which I know not.
The way of an eagle in the air; the way of a serpent upon a rock; the way of a ship in the midst of the sea; and the way of a man with a maid.

—Proverbs, 30. v. 18,19.

Intercourse unites the male penis and female genitalia. Complete or ideal intercourse implies a physical and emotional satisfaction resulting from this union of opposite sexes, irrespective of the possibility of fertilization. Potency is the ability to carry out the physical relationship with emotional gratification. A potent woman is able to receive the penis and experience orgasm. The inability of the female to carry out her part of intercourse is termed " frigidity ". The potent man is able to sustain an erection of the penis for penetration of the vagina, to experience an emission, exciting orgasm in the female, with full satisfaction and relief of tension. Impotence is the inability of the male to execute efficiently the physical side of the sexual act. Yet fertilization may still occur due to seminal fluid spilled at the vulval orifice, or some partial gratification takes place from the incomplete act.

A married man may be rendered impotent by his wife's unco-operative attitude or definite refusal to allow the act, or by his own illness or deficiency.

The Sexual or Mating Instinct

William McDougall (1936) defined instinct as " an inherited or innate psycho-physical disposition which determines its possessor to perceive, and to pay attention to, objects of a certain class, to experience an emotional excitement of a particular quality upon perceiving such an object, and to act in regard to it in a particular manner, or at least, to experience an impulse to such action ".

Instincts are developed in the course of evolution in relation to a specific problem; the sexual instinct for the maintenance and preservation of the species. All instincts are so purposive, are

performed independently of previous experience, the impulse arising from within the organism itself. An external stimulus coming to the body through the nervous system, causes the body to master it or fly from it. But as the internal stimulus, the instinct, cannot be dealt with by flight, some changes in the body itself must be effected through the nervous system if the stimulus cannot be satisfied.

Every instinct has a source, an impetus, an aim, and an object. The source is some biochemical or electrical change in an organ or part of the body from which there results a stimulus manifested in the mental life by an instinct. The impetus, is the motor element, the activity, the energy demanded for satisfaction. The aim is for satisfaction which occurs by abolishing the stimulation; different ways may lead to this same goal. The object is that through which it can achieve its aim. This is the most variable thing of an instinct and becomes attached to the instinct in consequence of providing satisfaction.

Sexual instincts are capable of arising from different sources, and both aim and object may be changed. According to Nietzsche human beings in their sexuality express their highest and lowest possibilities. Psycho-analysis (Glover, 1949) recognizes three main varieties of sexual excitation:

An adult sexual instinct
Infantile sexual impulses
Libidinal excitation existing in the various tissues and organs of the body

Freud (1934) showed that the instinct may undergo the following vicissitudes of reversal, a turning round upon the subject, repression, or sublimation.

The fore play, the gambit of attaining the love object, and the attitude after intercourse cannot be separated from the physical union itself. The preliminary play may run through all the infantile sexual impulses, and much may be learned from study of this phase. There can then be no one real method of normal intercourse, so long as fore play leads to union of the genitals with the capacity for fertilization, and a mutual satisfaction and benefit.

There is a socially approved normal, and deviations from this may arouse shame and guilt. In attempting to assess whether full adaption has occurred we must know the type of orgasm, the degree of satisfaction, and the resultant freedom from tension.

The Presentation of Impotence

When a patient attends the surgery he comes not because of physiological or anatomical abnormalities but because he is suffering.

His verbal complaints may shelter a latent disorder which he is unable to explain or vocalize; and much may be discerned from his behaviour which affords a clue. His posture, gait, facial expression and rate of breathing, changes of tone, hesitations, stammering pauses, or hoarseness indicate that the problem is yet uncovered; the problem is an intimate one, which must be coaxed out or the patient allowed time to tell his story at his own pace, in his own way. Normal history taking by direct questioning will not suffice; the doctor must listen, look, and feel. The patient speaks in two ways; firstly by vocal sounds, and secondly by the language of gesture.

Sexual problems are of this nature. A natural reticence to open a discussion on intimate life; feelings of shame of their ineffectual attempts at intercourse; reluctance to accept any deficiency as a sign of inferiority; disgust at the very mention of the word " sex ", means that the symptom is not often presented *per se*; and must be sought for in many outlying fields.

Cases of male impotence will be presented in four ways:

The patient comes
The wife comes
They both come, separately or together
An outside source reports to the doctor

The patient comes

1. *He complains of an organic lesion.*

Any interference with the anatomy of the genitalia or disturbance of the normal physiological changes of the body during intercourse may produce impotence.

(*a*) *Defects of the penis* itself may be congenital or acquired. Malformations are obvious on inspection. The foreskin stretching on erection may cause severe pain. Scars from burns of the skin or erectile tissue or diseases of fibrous infiltration of the corpora cavernosa and corpus cavernosum urethrae, growths, oedema and elephantiasis may alter the size, the ability to erect, or orgasm.

But much more commonly one meets lesions like herpes, a cyst, a dilated venule, which are presented as the condition causing, in the patient's view, impotence. The patient fastens on a temporary organic lesion to present his case.

(*b*) *Defects of the accessory male organs.* Commonly, acute gonoccocal, or chronic tubercular infection are responsible for premature ejaculation or failure to erect. Complaint that impotence is complete is common after removal of the prostate, no matter at what age the operation is performed. Orchitis following mumps or removal of a tubercular testes have been blamed by the patient for his incapacity, yet these cases are more probably the creation

of a psychological disturbance, consequent on disease, affecting the genitals.

Case 1. Mr. A. E. T. Aet. 49. In 1941, serving in the R.A.F. in India, he suffered painful orchitis for 10 days. There was no history of exposure. In 1945 his right testicle again enlarged and intercourse was painful. It was a seminoma; treated with deep x-ray, his potency declined and 6 years later intercourse twice a year caused him complete exhaustion. Testosterone injections were offered but declined.

(*c*) *Defects of the musculature involved in intercourse.*

Case 2. Aet. 50. Married at 43, his wife two years older. One year after unconsummated marriage attacks of lumbosacral pain, necessitating bed rest. Left lower abdominal pain six months later, x-ray investigations revealed no abnormality of back and bowel. Recurrent backache since. His wife had irregular bleeding but a D. & C. found no abnormality and her bleeding continues. He claims inability because of her constant bleeding; she states that whenever she has desire he has the backache.

Case 3. Aet. 44. Backache following digging in the garden. Some frequency at night for one week, tiredness and irritability due to overworking. No improvement after absolute rest in bed led to hospital investigations and diagnosis of a prolapsed disc. A corset was ordered which gave immediate relief. Only then did he volunteer that he suffered impotence for the last few months and deprivation must be hurting his wife.

A rectal prolapse, perianal haematoma, and an ischiorectal abscess have presented cases of temporary impotence. A mildly obese man complained of dragging in the groins and aching in the thighs without a discoverable cause, till his sexual life revealed impotence. The diagnosis of nocturnal cramps was offered me by a man of 38 who claimed his attacks were a normal concomitant of over four weeks sexual deprivation by his wife. (She was a severe hysteric with depressive bouts.) Could this be the explanation of nocturnal cramps in the elderly?

(*d*) *Defects of the surrounding organs.* A large scrotal hernia, a pendulous abdomen may impede the physical contact. If desire were strong would the obstruction be allowed to continue?

(*e*) *Defects of the hormonal glands.*

Case 4. Aet. 37. Came to me three years ago under observation for healed T.B. and clinical thyrotoxicosis. His B.M.R. and serum creatinine were normal but radio active iodine uptake proved hyperthyroidism, and his thyroid was removed. Married for 10 years, two children four and two but always ejaculation praecox, and his wife had never experienced orgasm. Two months before onset of thyrotoxicosis his mother died. Following his operation he enjoyed a short lived potency for two years. His wife, an anxiety hysteric, has been undergoing psychotherapy for six months.

Case 5. Aet. 40. Myxoedema and nocturnal enuresis of lifelong duration. A childless marriage for 16 years. His wife called him " Poor Tom ". His myxoedema was cured by thyroid, he gained control of his bladder but his impotence remains.

Gynaecomastia and small under-developed testicles were found in a routine examination of a man 5-ft. 3-in. tall, and weighing 10-st. 8-lbs., who sported a beard. I could have sworn he was

impotent but he described a healthy sexual appetite.

(f) Defects of the central nervous system.

Case 6. Aet. 38. Five years ago injured in a car accident, sustaining fractures of T11 and T12 and the right pelvis. A transverse spinal syndrome occurred complete below L1 on the right and L2 on the left, with a flaccid paraplegia. His sexual desire was still present, but now he enjoyed only the fore play. Over the last three years to help his wife he had attempted intercourse a couple of dozen times. He must lie on his side and mental thought alone produced an erection abnormal in its rigidity. His wife astride him union took place. He had no ejaculation. His appetite prior to the accident was above average.

Case 7. Aet. 49. Returned from the Far East with beri-beri. His peripheral neuritis cleared but he never enjoyed full potency. At first premature ejaculations and later complete absence of desire.

Head injuries even without definite concussion often cause impotence. Where compensation is involved the impotence may last until settlement of the claim. Grosser lesions of the brain through disease or trauma affect libido.

Electroconvulsive therapy and a prefrontal leucotomy have been blamed by my patients for lack of desire. Spastics marry and have children and a single young man of 24, a quadriplegia with choreo-athetosis, stated that he experienced desires for intercourse. The test of his potency is yet to be awaited.

2. *He complains of both organic and psychological symptoms.*

Case 8. Aet. 48. His neck was stiff, his left leg dragged as he walked, and his right arm was rigid by his side. Irritable at work, unsociable at home, depressed for years, he was a chronic attender at surgery. Colds necessitating odd days off work, nerves, gastritis, gastroenteritis, injuries to hands and feet, numbness of left thigh, and recurrent backache over the years. His marriage was childless. I asked him why? He claimed his wife was very cold. They'd had no intercourse for the last four years and rarely before that except in the first few months of married life, but he wouldn't dream of another woman. If I wanted him to come for interviews he would. Could I give him a certificate on those days, as he was on shift work? He lost his father when he was two; his mother had been wonderful, always working. Later he revealed she had thrown things at him, struck and kicked him but he never cried. She remarried when he was five, his step-father dying eight years later. At nine, " glands in the neck " necessitated six months at a residential school. On his return he was told by his mother " Your father was a dirty man. He caught a disease in China ". When 20 joined the services and in company with his only real friend (" a big brother to me, just like yourself, doctor ") had successful intercourse with prostitutes abroad. Married in 1943, one year after his mother died; he was fully potent. Employed as a sergeant in charge of transport, while his wife was a civilian clerk. Nine months later male drivers were replaced by girls. He suffered a nervous breakdown for six weeks. Continued in transport after leaving the service, his wife continuing her work. He did not desire children, as he feared he might pass on his father's disease. He had one good friend at work, others irritated him. " It's my fault doctor, I should have told you earlier. I can't write properly now ". Further examination left me undecided still. Was he indeed a parkinsonism? A consultant in neurology decided that " there was slight cog wheel rigidity of the wrist " and thought that he should be on artane, and was indeed a case of parkinsonism. The tablets made him sick. " I'll give the tablets a chance, and come to see you if they don't help me."

He is back, continuing his tablets, taking both artane and cogentin, his symptoms unchanged, and the months of struggle to regain his potency lie ahead.

All his efforts had been directed towards searching for his hereditary taint. His constant re-attendances at surgery, his variable complaints, his attempts to alarm doctors, and investigations at hospital to find the evidence which would confirm his mother's words. He needed a hard working mother or wife. His fear of being afflicted led to his assertion that he would never produce a child of his own and still later to his physical impotence.

3. *He complains of psychological symptoms.*

Case 9. Aet. 28. Unable to concentrate on his job, inefficient, slow, easily put off. Shy and afraid to look at people. What was the ultimate goal of life? Should he concentrate on his profession, journalism, or politics? Intercourse had been attempted with two girls. The first a nurse, working on a T.B. ward, gave him some tablets after he failed sexually. He tried again without success. He had heard that T.B. patients were given tablets to depress their sexuality. " I think she gave me those instead of hormones ". The second girl, had T.B., was 10 years his senior. His family were against the marriage. Intercourse was unsuccessful; the engagement broken, she married a man he despised. Learning she was pregnant he came South as far from home as he could. He had orchitis at 16; that might have been due to masturbation and perhaps affected his mind. He wanted lots of children and be a real patriarch. Could he have a complete check up and then have hormones? Here was a depression in a case of paranoidal structure.

4. *He complains of impotence.*

Case 10. Aet. 34. " I can't have intercourse with my wife; I'm not worried but she nags me and accuses me of having other women. I've a new job with additional responsibilities, I've been overworking. She says she'll leave me if I don't have treatment." Met his wife in 1939 at 17, engaged at 23, married at 25. The only girl in his life. Two children planned—aged nine and five, sexual appetite good until 18 months ago. Appetite diminished and for past three months ceased to exist. At five his mother collapsed at a concert, dying rapidly in hospital from tubercular meningitis. He spent four years with six different relatives. At seven he first openly learned of mother's death, his aunt who told him weeping bitterly. He saw the same aunt having intercourse, she cried out " the boy, the boy ". He thought she was being attacked and going to die. At nine rejoined his father " sharing a large double bed " for 18 months. Left his father to stay with a young lady and her mother; the young lady became his step-mother and both moved back to father's flat. He hated his step-mother until he was 14. She made him go to bed before father came home. He played truant from school and once ran away from home.

In 1940 he stepped into a moving railway truck in the blackout, sustaining concussion. 1941, in the services for six months but was invalided out due to blackouts. He was under medical supervision for three years. Worked with his father, a builder, a happy arrangement. A kindly uncle, heirless, offered him succession to his engineering business. Now established at managerial level, he realized he knew little of engineering but was prepared to continue studying for some time. He was confident that he could succeed. Three incidents stood out from his earliest years. Of playing with a metallic key of a gramophone and a sentimental waltz song, throwing a cat down an area to see if cats always landed on their feet (which this one did), and emulating his father shaving, using a cut throat razor resulting in a large scar down his face.

As he had attempted to emulate his father in childhood and scarred himself, so now fear of not being potent, a big business man, frightened him. Would he now show his ineptitude? Intercourse, like music, hurt and destroyed women. He must bury himself in his work and keep his energies for that purpose. His children aged nine and five reminiscent of critical periods of his life. His wife now nagged him like his step-mother did, and again he was with relatives rather than partnering the father he desired.

The wife comes

1. *She complains of physical symptoms.*

Case 11. Aet. 43. She complained of severe backache, a white vaginal discharge and amenorrhoea for 10 weeks. Married for 17 years and still a virgin, a complete examination was impossible. Intercourse twice, at her insistence, in the first year of marriage but never afterwards. Her husband worked away from home, could I please see him? The next day her period started; her husband never came. Four years later, chronic mastitis necessitated the removal of a fibrocystic lump. Another three years, backache, leucorrhoea, and rigidity in left abdomen. Examination under anaesthesia was negative. The gynaecologist offered her vaginal dilators but she refused saying it was too late. I have not yet seen her husband! A frigid wife and probably impotent husband. She desires sex after 17 years which he is unable or refuses to carry out. Was he satisfied away from home? She voiced no anxiety. He was impotent for her and presumably all women. It seems I shall never know but I think she was right.

2. *She complains of mixed organic and psychological symptoms.*

Case 12. Aet. 32. Since the death of her father and birth of her second child three years ago, severe dyspareunia, backache, intermenstrual bleeding, tiredness and depression. No intercourse for two years, two or three times in the six months before then. Her husband suffered migraine, looked terribly ill and the neighbours commented on this. A depressive reaction which cleared after one year's psychotherapy. She allowed him increasing access, thought of another child and I have not seen her husband for over a year. Having refused her husband intercourse for three years their first attempts led to his premature ejaculations. Now both are potent. The frigid wife leads to a forced impotence in the husband; the considerate type who will not force his desires on the woman.

Case 13. Aet. 40, with pains in her chest, a prolonged cough, loss of weight, insomnia and displays of temper to her four children. Her chest was clear and I asked what made her irritable. Her husband refused her intercourse, she replied. I saw him and he reminded me that two years before I had treated him for scabies. He was then working away from home; his wife accused him of infidelity and he refused to sleep with her. If I considered her condition could be through this deprivation, he would try and make his peace with her. Would I give him some tablets as he was not quite sure of his capabilities. I gave him a proprietary aphrodisiac. Some 4 months later I learned that he had been successful when I admitted her to hospital for a septic incomplete abortion. Was he guilty? Was he continent from indignation? Was he really impotent and cured by the aphrodisiac and suggestion? Was he pulling the wool over my eyes in asking for help, convincing me and his wife that he was not a sexual man?

3. *She complains of psychological symptoms.*

Case 14. Aet. 32 and married for seven years, c/o depression, irritability and insomnia. "Sometimes I think I'm going mad. I must get away from my husband." Early in marriage she feared intercourse. No bleeding followed their first attempt. "I wonder what my husband would think. I'd never had intercourse before. I think it was due to using internal sanitary pads." Her husband didn't object, didn't ask for intercourse but she masturbated him. For the last two years they practised fellatio. "He cried and pleaded with me until I had to do it." She was attracted to a man working on a building site across the road. She never spoke with him but felt he was interested in her. She willed him to come to her. He was all that was good in the world, her husband all that was evil. She read the Bible daily. She applied for a post as foster-mother/housekeeper. I advised her she was very ill and should return to her mother, and I would treat her. Could I treat her husband too? She was sure he was being blackmailed. I saw him, he admitted meanness, bullying arrogance and with reluctance impotence. He would do anything to get his wife back. I referred him to a psychiatrist for psychotherapy. Within two weeks they

were re-united in their own home but treatment will be carried on, for her frigidity and depression, and his impotence.

This case was exceptional, in that I had treated her father at the insistence of her mother, for impotence some 12 years previously. A course of testosterone led to potency for six months only. Her mother's nervous symptoms gave place to menorrhagia and a hysterectomy, thyrotoxicosis and operation, and later back to anxiety as bad as ever. I hope that psychotherapy may prevent all this in the daughter.

4. *She complains of husband's impotence.*

Case 15. Aet. 43. Married four years with mild myxoedema and anaemia in the past. " There is nothing wrong with me although I would like some more tablets. I wondered could you see my husband or tell me what to do. He has never made love to me since our marriage. He's shy and won't undress in front of me. He finds jobs to do when I want to go to bed, then wakens me to tell me what has happened in the office. He is good and kind, redecorates the house, and the garden is beautiful. I stopped work last year to prove my money wasn't necessary. I'm getting on, it will soon be too late to have a child. Perhaps it's being an only child but I'm an only child too. I know he was afraid of his father. He had a bad time at boarding school but he doesn't think there's anything wrong now."

Her husband rarely visited me. He was unduly deferential, clumsy, leaving the surgery with great haste, and repeated thanks. An appointment was arranged, but cancelled by the wife as he had a cold. I would visit him then, but he didn't feel up to it and would 'phone for an appointment, which I still await.

Case 16. Aet. 40 with sweating, palpitations, dyspnoea and insomnia. Her husband, recently returned from three years' imprisonment, made no effort to have intercourse. She had felt no need while he was away. He asked for time to settle down. I saw him one year later, for backache. He had little desire, intercourse was rare, but his wife was better. She had thought he might have a girl friend. He laughed.

I remember similar cases following the war, service men impotent on their return. Continence, the homosexual atmosphere of service and mild depressive states were variously blamed.

Both partners come, separately or together

Joint consultations for technique of intercourse, investigation of infertility, or procedure for adoption have revealed impotence. A man of 32, with exhibitionist tendencies, who later despite psychiatric help ended in the courts. The patient who wanted to be present at the examination of his wife but he was to be examined alone. He knew he was to blame for the infertility, due to removal of a tuberculous testicle at 14. He was impotent. Premature ejaculations feature prominently in this group, combined with mild cases of frigidity earlier on, in the wife. She recovers confidence, no longer fears penetration and the husband's anxiety to please leads to fear of failure. Her disgust, and agitation at each period lessens his confidence. Here I have, after a discussion with both partners together, advocated continence for some four weeks, exercises as

recommended by Van de Velde and alcohol, with success.

When both partners of a marriage begin to appear at the surgery, sexual deprivation should be suspected.

Case 17. Mrs. H., aet. 38 in six weeks, had a cold, a sprained ankle, a pain in the neck. Her child, aged three, was banging his head rocking the cot, her husband slept through it all. Mr. H., aet. 36, pains in the chest and a cold. His wife wanted no more children and premature ejaculations left him exhausted. The cost of a sheath was prohibitive. There was no need for treatment, as they were keen church attenders and would manage.

Outside sources report impotence

Ministers of religion, marriage guidance counsellors, social workers and welfare officers have, at different times, drawn my attention to the symptom manifesting itself as a marital problem. Here we find both sexual and social difficulties and it is important to assess the type of marriage, impulsive or prolonged courtship, the comparative ages, social environments and attitudes to parents and siblings.

Alcoholism presents in this way too, usually through relatives. The alcoholic blames his impotence on the drink and the necessity to drink on his job. Their refusal to acknowledge themselves sick, the denial of treatment in hospital makes the outlook gloomy.

Case 18. Mrs. B., aet. 30, an over-solicitous mother when her children were ill denied anxiety. I was informed by her father-in-law that she was separating from his son. His boy drank a bit, could I help? Mr. B. arrived obviously the worse for drink. He was early for his appointment and had slipped in for a quick whisky. His sexual life was all right, had he not two children? In any case his wife nearly died when her first pregnancy ended in a placenta praevia. No more pregnancies for his wife. He came to see me for six weeks and was abstemious. His wife developed bronchospasm, and a severe agitation. He relapsed and she recovered. Twice since has she gone to court to take out a separation order. He refused to enter hospital, his impotence and their problems remain.

Aetiology

1. Impotence occurs secondary to organic disease when erectal impotence, premature ejaculations, or ejaculatory impotence may result.

    1. Diseases of the genitalia and surrounding organs.
    2. Hormonal diseases, hypogonadism, hypopituitarism and hypothyroidism.
    3. Systemic diseases—such as diabetes, debilitating disorders, chronic poisoning, lesions of the spinal cord and radiation.

2. Psychological or primary impotence includes the vast majority of cases.

    1. A temporary lesion or operation on the genitalia precipitates a psychological impotence.
    2. Changes of the source, aim, or object of the impulse from the socially accepted normal occur.
        - (*a*) Although married, shows no desire for his wife or intercourse—complete impotence.
        - (*b*) Achieves potency, then regresses and fails—partial impotence.

(c) Achieves potency but not with his wife or with his wife after intercourse or handling of another woman—a relative impotence.

(d) He is capable and potent after his wife is unfaithful—a perversion. Other perversions I have met are fetishism, voyeurs, exhibitionists, a transvestite and homosexuals.

3. Aberrations of the fore play do not imply impotence.

4. Continence does not mean impotence.

5. Impotence is recognized as a disease when it occurs between adolescence and middle age.

The Incidence of Impotence in General Practice

A pilot survey was conducted of 100 consecutive attenders at surgery. All were married, with ages ranging up to 55, and their symptoms were unconnected with the genitalia or frank neurosis. 38 men and 62 women were interrogated. They were asked of sexual education before marriage; the sexual appetite early in married life and now, ideas as to normality and when desire finished; impressions of the partner and reasons for failure to achieve satisfactory intercourse or lack of desire. 20 males (52 per cent) had unsatisfactory sexual lives; 12 (31 per cent) due to their wives' frigidity; seven (18 per cent) due to their own deficiencies and one was continent due to the suspected infidelity of his wife, 15 years ago. 26 (42 per cent) women had unsatisfactory relationships; 19 (30 per cent] due to their own frigidity; seven (11 per cent) due to lack of desire or inability of the husband.

In these 100 marriages 46 had inadequate sexual lives, yet the union was neither difficult nor was gross unhappiness imputed. Neither husband nor wife of these 100 couples had approached me for advice or complained directly of the marriage. Could it be that illness was an actual replacement of the sexual deficiency? That neither the patient nor myself had correlated the two conditions?

A further group of 20 mothers (ages 26 to 37) bringing children for inoculations were then questioned. Seven said they had no desire for intercourse, four ever since marriage, three following the birth of a child. None complained that the husband was impotent but four stated their husbands were tolerant of their frigidity and understanding.

Not one male had admitted impotence, and when describing lack of desire a fuller history was taken. When was the last occasion of full potency? What were the first symptoms of lack of desire? Gradually the clear picture emerged that premature ejaculations and failure to erect had preceded this total inhibition. None

volunteered that they masturbated; one mentioned nocturnal emissions.

Where the wife complained of her husband's impotence, it was ascertained that her requirements were often really minimal. In both groups intercourse had not been attempted for years.

This sample is, of course, too small to have any real validity and another 100 men were questioned, cross checking when possible with the wife at her attendance at surgery.

In all cases of frigidity and impotence in patients under 45, the patient's answers were noted to be on the defensive; as if he or she realized that the deficiency was abnormal. Despite this, not one patient asked for self-help but three men asked for treatment for their wives.

Sex education. Only 5 per cent, all in the 20-40 groups, had received any competent formal instruction in marital relations, through lectures or books. All thought better education would have profited them.

The initiation of intercourse. 63 per cent of males said the desire for intercourse was mutual, and 37 per cent desire was shown by the husband alone. 51 per cent of females said desire was mutual, 37 per cent their husbands demands initiated it, and 12 per cent that they alone had to ask for intercourse in earliest days of married life.

In many the desire had changed. The reason advanced by both groups were much the same, first the birth of a child, secondly an illness of the partner.

Estimation of sex life. One man stated he had no desires until on his honeymoon, three others that desire for sex started at 18, the rest admitted impulses in early adolescence. Most women thought desire started in the early days of courting, at about seventeen. 70 per cent thought the sexual life finished at 50, ten per cent that it went on much longer and 20 per cent could offer no opinion. No male who had ceased intercourse considered it an abnormality. When it was suggested that senescence was the fading time of impulse, the taking of serpasil by a hypertensive of 45, gassing in the 1914 war in an anginal patient of 60, removal of the prostate five years before in a man of 60, the onset of rheumatoid arthritis at 40 and emphysema at 42 were blamed. This last patient said it was a familial tendency; his brother was stricken with asthma at the same age and died six years later of a coronary. It was peculiar, he thought, as both of them had frigid wives anyway. The male has great reluctance to accept total blame in sexual

matters. Or does the impotent man marry the frigid woman?

The sexual appetite. Satyriasis in earliest days to 24 times per month after 14 years in a man who had a trial marriage for three years, down to a regular once per month in a man of 26 after four years, in those cases claiming satisfaction. Some, whose wives were frigid, stated they had mechanisms for allowing intercourse on a few occasions, the firm's dinner, a trip up the river, boxes of chocolates on birthdays would help. " Why not arrange something similar every week? "—" She would see through that "—" Can't afford it." " It wouldn't be any use " were the replies. A man of 34 who asked for treatment of his wife said intercourse four times per month was allowed him only after pleadings and quarrels. When I saw his wife she stated he was an insatiable sexual maniac. His estimate was right, but unless she refused, his desires would increase. She saw nothing in intercourse, never had and never would. When I suggested that the rows might give her more satisfaction than intercourse, she smiled.

Correlation of physical illness and impotence. The presenting symptoms of the seven men admitting impotence in the preliminary survey were, three muscular, two cardiovascular, one respiratory and one skin lesions. Those complaining that their impotence was due to the wife's frigidity—four muscular, four cardiovascular, three respiratory and one skin lesions.

Where the wife had complained of her husband's impotence, details were elicited from his notes as follows:

Married at 33, phimosis and circumcision at 36, lumbosacral strain, recurrent boils. Two children, boys, 12 and 8. Wife—severe migraine, depression, a member of a family with Paget's disease, muscular pains.

Aet. 46; rheumatoid arthritis (variously labelled) knees, feet and hands. Fibrositic back pains, often off work. One boy 22. Wife, a cold, rarely attends surgery. " I've never felt so well since I've been to work " (since her husband's illness).

Aet. 42. Coryza; epigastric pain on one occasion. Wife recurrent bronchitis and backache.

Aet. 50; indigestion, lumbosacral strain, perianal abscess, fistula in ano, carcinoma of left vocal cord; two children, one from his previous marriage. Wife anorexia, loss of weight, bronchitis, anaemia, chest pains and always ill before every holiday.

Aet. 54; recurrent depression, two children, 30 and 26, both married. Wife otitis externa, deafness.

Aet. 46; healed T.B., appendicular colic, stiff back, multiple injuries at work deafness, sacroiliac strain. One boy 23. Wife, T.B. thyrotoxicosis with subsequent myxoedema.

Aet. 41; no attendances. Wife 40, diabetes. No children.

The latter cases fell into the same categories:

Recurrent physical illness, usually mild, of cardiovascular, respiratory, skin and muscular systems with a smaller number of gastro-intestinal cases. The same patient manifested different complaints over the years; he was in the

chronic attender group. Would all chronic attenders be the same?

The patient with neurosis or psychosis.

The patient with complete impotence who rarely attends the surgery, indeed according to his record card would be a first class life.

The chronic patient. When those who are constantly attenders at surgery were interrogated the positive agreement was high, over 80 per cent admitting impotence or frigidity, in either or both partners. In the few with whom I undertook a fairly exhaustive survey, it was also noticeable that the appetite had never existed to a great degree, although the patient tended to create the impression that the physical illness were causative. It would be easier to assume chronic ill health leads to impotence but here was evidence that the reverse, impotence the primary, ill health secondary, was the case.

Coronary thrombosis. Two young men with coronary thrombosis confirmed by E.C.G. revealed healthy sexual appetities with deprivation for over eight months, immediately preceding the attacks. Their ages were 28 and 32. Both were engaged in sedentary occupations but over-active in the house. The wife, in each case, was pregnant; the first had been advised to avoid intercourse because of a retroversion, the second because of a previous threatened miscarriage. Both couples applied the advice too literally. A third man of 40, a games master, gave a similar history. No intercourse during pregnancy, the wife frigid after the birth of the third child and no sexual connection during the following six months, because the baby was breast fed—(his wife's advice).

A further correlation was found in a man of 48. Tired, overworking, he lay awake at night for months. He wanted his wife to comfort him " to be motherly and cuddle him ". This she never did, as she expected overtures from him. In bed during his attack he was at last able to tell her of this. She stated he was accusing her of his heart attack. They now are able to indulge in the fore play but no sexual connection has occurred since the attack. Another case revealed no intercourse for 22 years in a man of 57, a shopkeeper. His wife was frigid after the first month of married life. During this long period of abstinence he had approached his wife on a half a dozen occasions only. She excused her frigidity on the grounds that her husband would bath and change his clothes only once per week.

It seemed possible that a sedentary occupation and deprivation of intercourse with a strong appetite might be a predisposing cause for infarction. Where the appetite was weak a much longer deprivation might lead to the same result. If the patient were engaged on active muscular work, release of his accumulated tensions was easily facilitated. Three other coronaries denied loss of appetite

prior to their attacks but all admitted no intercourse following the attack.

Acute illness and impotence. An acute illness was often the trigger point of impotence. The diseases ranged from gastro-enteritis to a major stroke. It was noticeable that wives more often than the husbands thought no intercourse should take place. Many wives coincidentally resumed work at this period, a large group in the very early forties; a useful positive symptom.

The commonest cause. A frigid wife with vaginismus or abnormally low appetite often finds herself a husband, impotent, or with low drive. If his appetite is great he forces his desires on her, finds consolation elsewhere, sublimates into social activities, or canalises into chronic sick health. The frigidity of the woman causes impotence of the man.

The commonest symptom. In general practice, backache is the commonest presenting symptom. Cases, even with mechanical defects or degenerative processes, will show a figure of at least 60 per cent of impotence occurring before the complaint of backache. Other symptoms are the requests for tonics, self medication with proprietary medicine, the inability to wear a contraceptive sheath, exhaustion and overwork.

The Possible Mechanism of Symptom Formation

An instinct compels action through the central nervous system. When unfulfilled, the energy expends itself through the autonomic pathways. During sexual excitement the physiological changes, tremulousness, sweating, increase of respiration, rise in blood pressure, tachycardia occur in a state of unawareness of the surroundings, reaching exhaustion and relief with orgasm. The adrenaline forming sympathetic and the insulin increasing parasympathetic control homeostasis, the stability of the internal environment. The hypothalamus controls the pituitary, reflex emotional expression, skeletal muscles and carbohydrate metabolism. The uncompleted instinct finds expression through the autonomic nervous system and the same changes are produced, but without relief and the patients awareness of inexplicable changes of muscular tensions, cardiovascular and respiratory changes, shakiness and irritating moist skin (a nidus for infection), on which his attention becomes focused, brings him to the doctor.

The Prognosis

Where impotence occurs in the course of a treatable organic illness the prognosis is good, most dramatically in gonad deficiency treated by testosterone. It is as well to remember, as shown by my patient with phimosis operated on three years after marriage,

that the mechanism, anxiety, fear and loss of confidence arising through physical impairment, do not disappear spontaneously. It has led me to discuss with every patient undergoing operative treatment round the pelvic area what were the fears, anxieties and anticipation of the subsequent sexual life. The medical examination alone may be a valuable therapy.

Where partial impotence is complained of by the patient himself the prognosis is good. It implies the will to recover, the intelligence to anticipate and avoid marital rupture. In all cases, the wife should be interviewed. Her adoption of a sympathetic motherly attitude, reassuring that her love and respect for him are unchanged, despite his failures, with continence for four weeks renders a dramatic change. We have seen that impotence is a symptom of sexual dysfunction involving both partners and the cause lies more often in the female. Not many cases, therefore, will respond to this reassurance and therapy by suggestion. Premature ejaculations during the engagement lead to increasing fears of the honeymoon. Impotence in the course of a paranoidal illness, depression or severe neurosis has the prognosis of that illness. With simple anxiety and hysteriform reactions, psychotherapy, often prolonged, will create a good positive readjustment of attitudes and the prognosis is good.

Where impotence is complete, the patient rarely comes to the doctor; the total inhibition protects him against unconscious anxiety and guilt. Only through the wife or outside sources do we learn of this affliction. When exposure is imminent, his social marriage threatened and his facade endangered, then he comes. If his wife is completely frigid and their marriage not jeopardized, he remains content. When both lack appetite the prognosis is poor, their characteristical attitudes are too rigid, resumption of previous attitudes too easy for any treatment to be effective.

No attempt has been made to assess the figures of impotence in the general population, but the findings of Kinsey, Pomeroy and Martin (1953) are at total variance with those I elicited. My practice lies in a dormitory area of London, middle class, and the incidence of other diseases are representative of the country as a whole. I have no reasons to believe that my patients' ignorance and lack of education in sexual matters, their attitudes or unconscious following of family patterns or incidence of neurosis can differ widely from other spheres with the same cultural and environmental background.

The virgin soil of the child's mind must be fashioned to a more open, frank, knowledgeable, healthy, mental attitude; the fertile thoughts of the adolescent educated to the responsibilities and

practices of marriage and the adult then need plough no lone furrow.

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THE COLLEGE OF GENERAL PRACTICE OF CANADA

The November issue of the Canadian College's *Bulletin* maintains the high standard of former issues. Pride of place is given to an appeal for testing urine of neonates in a routine search for phenylketonuria, and there is an excellent article giving the facts about this condition and the importance of detecting it early. Other articles show that postgraduate education is the main activity of the College. For instance, there is a list of tape-recordings held by the new library for issue free to all members, there is a comment that a postgraduate cruise visiting Bermuda and Nassau has already attracted 300 bookings (730 are wanted), and there is much information about the projected convention in Vancouver in March 1961. Articles on the treatment of depression, and on acute pancreatitis are included.

Advice is given that faculty activity is the mainstay of College effort, and faculties are recommended to chart their membership distribution to find areas which need attention, to keep an inventory of " interested members " and to try to find means of having them meet and work on College schemes, and to enlarge the representation of College committees, etc.

Similar problems to those seen in the U.K. confront the Canadian general practitioner. ". . . one sees examples of situations where a specialist should take complete charge of a case but has difficulty in arranging for this; and other situations where he should leave the care of the patient entirely to the general practitioner, but instead of that he tries to run the whole case." And again, ". . . much of the course to which medical students are subjected is redundant and equally, much of what is needed is omitted. . . How to alter this. . . provides a problem of the first magnitude."