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Physicians frequently encounter questions about sexual functioning, or dysfunctioning, in the course of routine practice. Not infrequently the patient's presenting complaint is related to concerns over sexual adequacy. How are such questions handled? Does the physician feel frustrated or embarrassed? Does he turn the patient off or does he listen and try to help him? If the physician has not studied and pondered the issues involved in sexual dysfunctions, it is likely that he will fail to grasp the psychological complications related to sexual problems. It would seem useful, therefore, to explore some of these issues so that the physician will feel more competent in dealing with sexual problems of his patients.

The theme of this article is limited to male sexuality, and my discussion will assume the context of twentieth century America. This is not the place to investigate the sexual practices and problems of our society, but I should comment about the ongoing "sexual revolution." Adults in our society, as a recent magazine observed, read about, see and talk about sex more in a year than their parents did in a lifetime.

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Censorship has been fighting a losing battle in all areas so that by now there is a little left to the imagination. Yet with the increasing openness about sex and the increasing information available about sexual functioning there seems to be an increase in the number and severity of sexual problems. Now one may argue that there is no established relationship between the two phenomena or that people today are simply more open about expressing their problems. I have no objective material to counter such arguments, but my clinical experience in a variety of settings – general health as well as psychiatric – shows a significant increase in sexual problems over the past decade. And for every patient who is referred to the mental health professional I would estimate five or more who are seen by the physician in general practice.

Why is it that sexuality for the male is such an emotionally-charged issue? Why is so much shame or anxiety attached to sexual dysfunctioning and not to other kinds of dysfunctioning? It is my hypothesis that the emotions are more intense for the male with sexual problems because of the close relationship between these problems and his sense of identity. It is admittedly difficult to separate the psychological from the sociocultural aspects of this issue. The sexual openness and permissiveness of our contemporary society seem to be major factors contributing to the increasing number of sexual problems. Our society says to the male: you are a man to the extent that you demonstrate your sexual prowess. The male is led to believe that he must prove his masculinity, to himself and to others, by his sexual functioning. The male picks up this message and begins to evaluate his performance. If he fails to function according to expectation or desire, his own or his partner's, he experiences some apprehension and anxiety, which in turn begin to affect his performance. I am thinking specifically of impotence and premature ejaculation. Such problems are not related to certain age, marital status, or economic level, although the younger male seem to be more open in discussing the problem.

I follow Masters and Johnson (1970) in distinguishing primary from secondary impotence and also in classifying premature and incompetent ejaculation separately. According to these authors, primary impotence is that in which the male has never been able "... to achieve and/or maintain an erection quality sufficient to accomplish successful coital connection." (1970, 137). Secondary impotence is considered to be erectile failure after at least one successful intromission. Since impotence is such a widespread problem in our society I will use this dysfunction to explore the relation between male sexuality and the sense of identity. Let me begin by stating that I consider impotence to be a symptom of the problem rather than the problem itself. This physiological symptom is directly related to the psychological symptom known as anxiety, and most often there is a cause-effect relationship between these two symptoms.

Anxiety is that non-specific fear or apprehension experienced when a person feels threatened. The anxiety may be attached to a physiological function but investigation will generally reveal multiple underlying factors which contribute to the anxiety. Consequently, the first task of anyone treating an anxiety-related symptom such as im-

potence is to determine the primary etiological factors. These may be physiological, psychological, social, sociocultural, or ethico-religious. Masters and Johnson (1970, 161ff.) have done a signal service in discussing the most common etiological factors contributing to impotence. Anyone who finds himself treating patients with the problem of impotence would do well to acquaint himself with the Masters and Johnson discussion. Understanding of the various possible factors is particularly important in determining goals as well as limitations of treatment. Can impotence be treated as such when there is a prior or simultaneous problem of alcoholism? How far is the therapist able and willing to delve into the underlying personality structure to get at the roots of the alcoholism-impotence symptomatology? Often the therapist will find in such cases a passive-dependent personality with feelings of worthlessness and inadequacy. Such a person may feel increasingly unable to face and cope with the demands of adult life. This person may turn to alcohol to blunt the nagging selfdoubts and to alleviate the continual anxiety, and the alcohol in turn may bring about impotence. More directly, his fear of losing his independence may be related to impotence through fear of closeness and deeper fear of castration.

Although fear of closeness is not age-specific, it seems more prevalent among the males from puberty to the mid-twenties. This would be expected if one takes as the primary task of this period the process of clarifying one's sense of identity. I have found it helpful to use Erik Erikson's developmental sequence to define the tasks characteristic of a given phase of psychosexual development. Erikson suggests (1950, 1968) that until the adolescent succeeds in establishing some sense of identity he is incapable of getting involved in the kind of intimate relationship implied in marriage. Because of the prolonged period of adolescence in our society it may take an individual a decade or more to gain an inner sense of confidence and assurance in himself so that he feels safe in relating to others. I attribute the length of time needed by the male in our society to develop a sense of identity to two sociocultural factors. First, on all socio-economic levels today the father tends to be absent, either physically or psychologically, so that the adolescent does not have a model to control and direct his growth toward adulthood. Second, as our society has become more complex it has taken more and more time to prepare the individual to assume his position as an autonomous, responsible adult. During this preparatory period, extended economic dependence involves extended emotional dependence, resulting in a retardation of the psychological growth process. The core of this process involves occupational identity as well as sexual identity, both of which contribute to one's sense of personal identity. To the extent that either is undeveloped or distorted the individual will not only feel unsure of himself but will feel threatened by any kind of personal closeness.

At this point I would like to present and discuss a case which illustrates in a striking way the relation between impotence and identity. The patient was a 20 year old single, white male college student referred by a school counselor because his "lack of confidence" and his tendency to become absorbed in peripheral details was interfering with his academic

work. Note that the presenting complaint did not include mention of impotence. Only upon my pursuing the issue of his lacking confidence did he mention his primary concern and major example of lack of confidence. Reticence such as this is frequently found surrounding the area of sexual dysfunction so that the patient needs encouragement to express what to him is not only a sensitive but a shameful matter. In the present case it took the patient over a year to get enough courage to come in for help, although once in my office he blurted out his secret within the first few minutes. In other cases it has taken several visits to get at the real issue.

With younger patients the initial experience of impotence is generally so traumatic that the details are recalled exactly as they occurred. My patient described a "weird incident" that had happened to him the year previous to our first session. He had been studying for examinations and had been taking amphetamines to stay awake for two days. In the midst of the studies his girlfriend called and asked him over to her apartment for the night. He attempted to have intercouse but found that he was impotent. After that experience he became depressed and socially withdrawn, afraid to risk another failure. The patient at first had no insight into his attempt to rationalize his impotence by attributing the dysfunction to fatigue and drugs. The anxiety aroused by the initial trauma was so great that he felt compelled to avoid any situation where he might again be put to the test. Regardless of what defense he tried, whether rationalization or denial or avoidance, his sexual dysfunction remained to haunt him. What was for him the primary proof of his manhood was gone, and the consequent feelings of inadequacy radiated in all directions. He became concerned that his impotence with females might mean that he was homosexual, and so he began to withdraw from contact with males as he had from contact with females. But he found that he could not tolerate the feelings of isolation and loneliness that accompanied his social withdrawal. His increasing depression affected his academic performance and he decided to withdraw from school for a semester. It was the time of his return that he was referred to me.

After the general evaluation I set the patient for a three-month period of psychotherapy. The patient gradually accepted the fact that there was no "quick cure" for his problem and gained considerable insight into the major etiological factors even in a brief a period of time. He came to realize that his impotence was related to deep feelings of insecurity and inadequacy. Here was a passive-dependent person, quite immature as regards the level of ego development and degree of impulse control, with a correspondingly nebulous sense of identity. Long-term, insight-directed psychotherapy was recommended and with reassurance from the therapist I felt that the prognosis was good. He has accepted his impotence as a symptom and has shown a willingness to explore the underlying causes. With this as a beginning, I would expect slow but continual progress and eventual alleviation of the symptom of impotence.