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Impotence

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A THESIS

IMPOTENCE

SUBMITTED IN PARTIAL
FULFILLMENT, AS REQUIRED,
FOR THE DEGREE**DOCTOR
OF MEDICINE

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IMPOTENCE

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INTRODUCTION

²No appology is necessary for discussing disturbances in the sexual function because these ailments are so common and of such importance, not only to the victim and his family, but to the entire community.

Neurologists do not possess the necessary technical skill requisite to examine the genital organs, and the genito-urinary surgeons lack the knowledge of the neurologists. Thus the victim of the sexual disfunction, suffering mentally and physically, wanders from one physician to another seeking relief, until he becomes obsessed; if married, his wife is subject to needless operations and examinations to cure sterility, when, in fact, he alone is at fault.

²⁸Though it may sound elementary, it may be said at the outset that erection should occur in the normal man almost simultaneously with the stimulus of strong sexual desire and favorable opportunity, and should be maintained until consummation of the act in detumescence after orgasm. Any deviation from this standard, whether it be in the form of deficiency of erectile power or premature ejaculation (which is often the first step toward impotence), represents a corresponding degree of sexual impairment which requires correction. It is important, however, to remember that all human beings differ in their natural sexual equipment. We are all born with a definite, inherited sexual endowment, which makes itself manifest throught life in a corresponding coefficient of sexual virility. The endo-

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crine system undoubtedly is responsible in a large degree, if not altogether, for the character and maintenance of this coefficient. In some individuals it is strong, in others weak, and in between these extremes there are as many degrees of sexuality as there are human beings.

^{ad} It is surely no exaggeration to state that among civilized humanity inadequate male sexual performance is one of the very prevalent causes of the most poignant misery and unhappiness. Seldom does a physician hear any complaint so tinged with bitterness and despair as that of the patient reporting insufficient sexual function. Equally distressing may be the story told by the wife of such a man. The psychology of this unhappiness is not difficult to understand. Virtually every human being visualizes a love ideal in which perfect sexual union is an essential element. In addition, the idea is a mistaken one, but none the less widely prevalent, that sexual impotence necessarily implies ruinous impairment of every virile quality of the personality. Thus, severe sexual inadequacy is quite certain to disrupt the entire love theme, bringing to the man humiliation, disillusionment and feelings of deepest inferiority, and to the responsive woman a bitter and perhaps unendurable disappointment. The ultimate result is frequently neurosis added upon neurosis until the integrity of the personality is seriously disturbed. Only the occasional exceptionally well sublimated individual is able under such circumstances philosophically to resign the sexual life without apparent

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personality damage.

The seriousness of inadequate sexual performance is added to by its incidence. While specific figures are almost impossibly difficult to obtain,^{a3} Stokes believes it to be approximately 10 percent of the entire male population of this country. In this estimate, only those cases are referred to in which the difficulty is so pronounced as to cause acute dissatisfaction. Some degree of impairment of potency is the rule in our present civilization. The fully, consistently potent man is the exception, for reasons which shall be stated presently. One should not fail to consider that the number of men who are driven to seek aid because of impotence is considerably reduced because of the fact that so many women are sexually fringed and therefore do not complain of the impotence of their husbands.

^{a3} All that is generally known about male impotence is the inability to effect the procreative union, through failure of erection. The existence of any other kind of impotence is known to only the sufferer himself. All the subdivisions of the anomaly of impotence are veiled in complete darkness. They are entirely unknown to the laity. Even the profession is not well informed about the subject. It is only familiar with the manifestation consisting in the failure to perform the function of conjugality, because it is on this account mainly that the patient seeks medical advice.

This advice is not seldom given in a perfunctory manner. The condition is made light of and is dismissed with a suggestive mocking smile. Still impotence in all its

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manifestations is not a subject to be laughed at and ridiculed. It is not only of great importance to the individual sufferer, but also of moment to the health of the family, hence of great social significance.

²⁷
The physician must deal with disease, its cause and effect, and it is not part of his duties to moralize. This includes both mental and physical disease. If sexual function, which is perfectly natural and normal, is not exercised for any reason, sexual potency will be diminished and, according to Steinach, Woronoff, Sand and others, senility and loss of both physical and mental virility will follow because they are closely associated with sexual potency.

The economic and educational conditions of civilized society today and the barriers being set up against the exercise of normal functioning are becoming responsible for a large amount of immature sexual impotency. It may be stated almost as a rule that sexual impotency varies directly with the progress of mental development and civilization. Whether this is a biologic problem is a question which the future must answer. Certainly impotence as well as other causes tend toward the extinction of the fittest and to the survival of the "unfittest".

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HISTORY

The history of impotence undoubtedly dates back as far as the beginning of man, although it was most certainly less prevalent during the early times.²⁷ According to some writers however, the more civilized people become, the greater the spread of impotence. Under these conditions there is a tendency to supersublimation and direction of energy into other fields other than that of sexual gratification which results in a lessening of the desire. Also the present standards of social organization discourage sexual relations excepting under especial conditions, (marriage). As we shall see,¹⁰ Stekel goes as far as to say that supression of the sexual urge under any conditions tends to reduce the potency.²⁷ It is an historical fact as well as one observable today that the lower grades of human society are more prone to sexual promiscuity than the higher classes. If it were possible to obtain records down thru the ages one would thus in all probability find an increasing incidence of impotence as civilization became more specialized.

The treatment of any case of impotence naturally depends on a correct diagnosis. In as much as the success of treatment depends on this knowledge, it may be said that the history of the treatment follows very closely the ability of the physician to correctly diagnose the case with reference to the underlying etiology.

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ETIOLOGY-PSYCHIC

Welfeld believes that in true psychic impotence, that is, without organic cause, that there is no real impotence. The patient really has potentia coeundi et generandi, but he imagines and is convinced that he has not. Every physician knows that a fixed mental idea suffices to inhibit actual organic functioning and literature abounds with examples where organic dysfunctioning results from purely psychic causes. Furthermore, the actual symptoms of disease may be simulated or suffered by psychotics where the actual disease does not exist. It is not difficult to understand then that under the circumstances patients may fully convince themselves that they are impotent and may, by the force of such mental conviction, be unable to perform the sexual act, although in reality nothing but their state of mind prevents them from doing so.

Psychic impotence in males today is far more prevalent than is commonly believed. It is no exaggeration to say that most cases of impotence as seen by the urologist today are of this type. We will find that in the majority of these cases the condition can be traced back to the restrictions placed by our present day accepted standards of social morals and civilization on the exercise of normal sex functions.

When we question the causes underlying this development of civilization and progress, we find that economic factors and standards of living are such that a large number of men cannot afford to marry, at least not while young.

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Many deliberately suppress their normal sexual desires; others abuse them to excess without the responsibility of marriage. Those who do marry do not exercise their functions normally because they do not want, or cannot afford children; and women, if not actually averse or even hostile to intercourse, submit to it unwillingly rather than acquiescently. Civilization and higher education tend to regard the exercise of the sex functions as brutal and degrading, and morality teaches sublimation of sexual desires. All these factors in one way or another favor sexual impotence. The medical man sees that on physiologic and hygienic grounds modern tendencies cannot be reconciled with the observed clinical facts. Many of these patients are in a subschizophrenic condition, depressed, morose and dissatisfied.

McCartney gives as the factors in psychic impotence, fear of consequence, aversion to partner, aversion to the sexual act, jealousy and psychic shock in nervous individuals who are highly impressionable either congenitally or by upbringing.

Fear or anxiety, according to McCartney is frequently the most important cause of sexual failure, especially with those who have had a mawkish training. Being subject to emissions, they know of the after weakness and the reading of literature increases the fear in their minds. They continually dwell on supposed mental decay and loss of manhood, and first attempts at coitus are failures. Later, a jest or taunt or worry may result in failure also, and they gradually grow impotent.

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There are many men who on account of the indifference or evident aversion of their conjugal partners to coitus have gradually suppressed their emotional sexual feelings and weaned themselves by degrees from the practice of the sexual act. Having a high sense of rectitude, of fidelity to their spouses in sexual matters, they have never thought of other women, they become deeply absorbed in business matters. After living several years of suppressed sex life they find that they are impotent in regard to their conjugal partner and fully believe themselves to be completely so.

²²
In another class there are those who have for years suppressed sexual desires and have forced themselves to continency for other reasons. The final result is that they believe themselves completely impotent also.

In order to insure a clear concept of the precise nature of the disorder under discussion, a working definition will be established. The term "male sexual inadequacy" shall be assumed to include any inability to secure erection, by ejaculation before intromission, by inadequately brief intravaginal voluptas, by exceptional difficulty in reaching ejaculation or by the requirement of an unusually long recovery period following ejaculation.

Certain of the elements in this definition demand further explanation. For present purposes the terms "ejaculation" and "orgasm" may be regarded as synonymous. By erection is meant a full erection capable of being maintained at intromission. By inadequately brief intravaginal voluptas is meant an unsatisfactory shortening of the time elapsing

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between intromission and orgasm. Here no precise time can be assigned, but certainly if this phase is repeatedly under 1 or 2 minutes and is invariably followed by prolonged loss of erection there can be no hesitancy in concluding that inadequate function exists, for few normally responsive women could possibly be brought to detumescence through such a performance. As an actual, practical fact, the adequacy of the intra-vaginal voluptas must always be estimated with reference to the specific needs of the sexual partner.

In the definition is mentioned exceptional difficulty in reaching ejaculation despite satisfactory erection. The individual displaying this phenomenon is likely to enjoy a somewhat false reputation as a sexual paragon, for he can of course provide an extraordinary amount of vaginal stimulation, even if his own orgasm is never attained and his satisfaction slight.

The final phase of the general definition deals with the requirement of an unusually long recovery period following ejaculation. Poor libidinous rebound is characteristic of virtually every type of impotent behavior, but I am making a special case of the individual who reaches a first orgasm in an apparently adequate manner only to lose all ability to regain erection under continued stimulation. The specification of normal rebound time is impossible, although it should be a matter of minutes rather than of hours or of days. The most vital factor in its estimation is the corresponding demand of the sexual

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partner for further stimulation.

As an introduction to the etiologic study of these disorders that have been defined, an interpretation of the relatively normal sexual performance by means of a graphic chart, will be presented. For this purpose we shall assume the sexual contact of an experienced, fully potent man with an experienced, responsive woman, under ideal emotional and environmental circumstances. (See graph 1).

Here the most significant observations are: (1) Good erection well maintained, (2) satisfactory prolongation of the intravaginal period of the voluptas, (3) an excellent rebound after the orgasm, decreasing progressively after each successive ejaculation, (4) a voluptas constantly positive, with no swing to the negative side of abhorrence and disgust.

Next a series of graphs will be presented, delineating the various types of inadequate performance that have been mentioned. Graph No. 3 of this series illustrates the libidinous behavior of the individual who cannot command an adequate erection. Graph No. 3 deals with ejaculation before intromission. Graph No. 4 concerns inadequately brief intravaginal voluptas. Graph No. 5 represents involuntarily excessive excessive prolongation of the intravaginal voluptas. Graph No. 6 indicates the performance that is relatively normal except for a deficiency of the libidinous rebound.

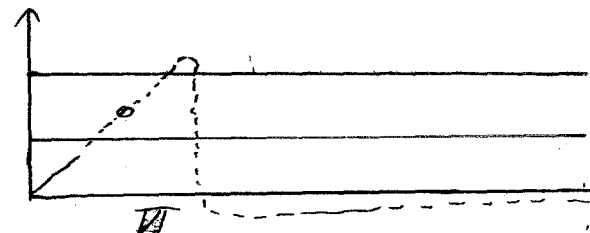
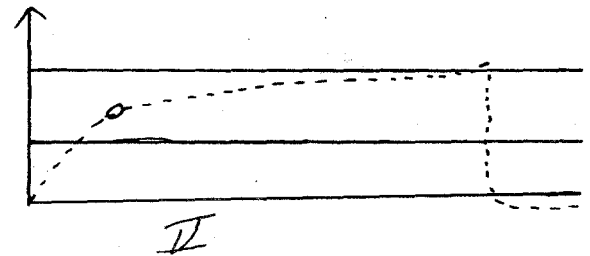
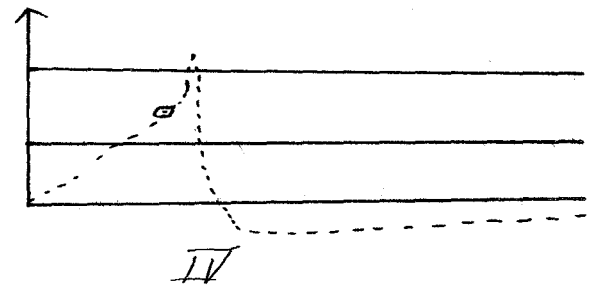
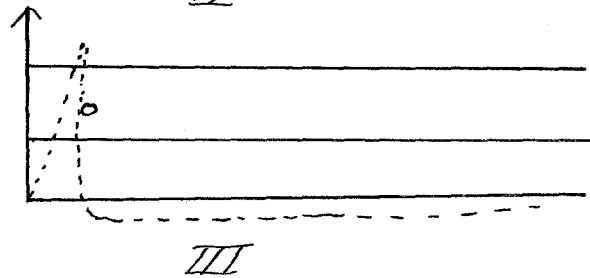
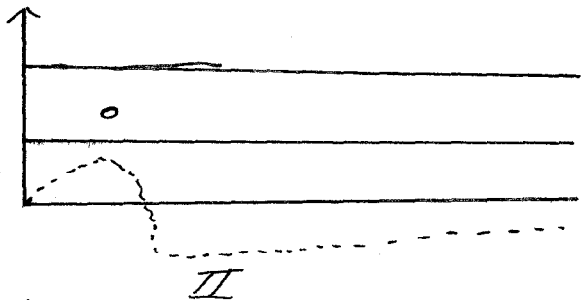
Graphic Line = Libidinous Progress
o = Intromission

Orgasm Level
Full Erection Level
Resting level

Intensity of Voluptas

Stratum of Ecstasy
.. Intense Voluptas
.. Moderate ..
.. Negative Voluptas (Aversion)

Graph I (Normal)



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As one reviews these graphs it is seen that all of the various inadequate performances have two common factors: an insufficient libidinous drive and a terminal swing to a negative voluptas or reaction of disgust and aversion. These observations suggest a key to the situation. One naturally wonders how it can be possible for such an enormously powerful biologic endowment as the libido to fail so dismally. The following causes suggest themselves: (1) an hereditarily weak libido, (2) functional weakening due to local or remote organic pathology, (3) a requirement of some lacking or different stimulus, (4) the presence of libido-crushing fear.

The first of these four factors may be dismissed as of little importance. Undeniably there is a certain hereditary variable in the potency equation, but even the lesser grades of hereditary libido endowment are amply sufficient to insure a good sexual function if given a reasonable chance at natural development. Positive evidence of this occurs in the fact that serious lack of potency is unknown among primitive orders of man who follow a simple biologic pattern in the sexual life.

The second factor, that of local or remote organic pathology, must always be given careful consideration.

The answer to our question is contained, in part at least, in the third and fourth factors mentioned: that is, to a requirement of a lacking or different stimulus or to the presence of libido-crushing fear. These potency destroyers are largely or wholly a product of civilized ideals

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and morals. Just as surely as civilization has in many ways expanded and enriched the erotic life, so has it impeded its expression in other ways, chief among which are: (1) The frequent association of libidinous expression with requirements impossible of realization, (2) the creation of a domination fixation upon some sexual component other than the heterosexual, (3) the association of sexual expression with fear and danger typically through the doctrine that sex is sin.

Working from this general viewpoint of the etiology of impotence one knows how to proceed in explaining that weakened drive seen in every case. Always the libido must be doing one of two things, either straining in another direction in protest against inadequate present stimulus, or struggling with fear. And once the present stimulus has exerted its maximum lifting effect, the libido is overwhelmed by its burden, hurtling downward not only to the resting or neutral level but crashing beneath it to the negatively toned stratum of disgust and abhorrence, where it is further firmly anchored by the added weight of an intruding sense of failure and humiliation.

²³ Talme^y's reasoning in relation to psychic impotence is along the same lines as that of Stoke's, but is sufficiently different to be of interest. It seems to be quite well agreed upon that psychic impotence of copulation is the anomaly met with in the higher strata of society, among the cultured classes, workers, captains of industry, high

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officials, and busy professional men. Among these people psych impotence is even more frequent than atonic impotence is among the general male population, which will be discussed presently. In psychic impotence it is the cerebral inhibition center which is in a state of exaggerated excitation. In the normal man, at an adequate erotic stimulus, an impulse is sent from the cerebrum to the centre of erection. In psychic impotence the impulse is inhibited from being sent. Psychic impotence is hence due to a certain state of the mind. The differential diagnosis between psych impotence and all the other forms of impotence is the phenomenon that in psychic impotence the anomaly disappears when the psych is out of commission, as in sleep. In psychic impotence the erections are quite vigorous during the state of sleeping. The patient awakens towards morning with strong erections. But as soon as the psych begins to function, the erection ceases, while in the normal the erection remains in the priapic position for a certain length of time. These strong morning erections are not seldom utilized to effect a cure, if the wife is willing to participate in the medical management of the case, as this one: Mr. N., thirty-five years of age was always normal in his marital undertakings, which were not successful following the armistice. During the war he had under his supervision great problems which tasked his nerves to the highest degree. After the nervous excitement was over he found his erections to be very feeble when he tried to ap-

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proach his wife. His morning erections were as strong as ever. His wife was advised to watch him in his sleep and if she noticed a strong erection she should suddenly awake him and cause him to effect conjugality. This she did and succeeded. One such success cured the patient.

Psychic impotence is sometimes only transitory when the patient is in a state of agitation. The more agitated the patient is the more the penis shrinks at the critical moment. It does not expand and feels cartilaginous. The anomaly disappears, as a rule, with the disappearance of the agitation.

One such failure during an accidental agitation not seldom may cause a psychic trauma through the subconscious effects of cryptogammic nerve currents. The emotional trauma is conserved as an isolated neurogram and may become the substratum of future anxiety attacks at every critical moment, the emotional ideas having constituted a permanent complex. In this way an occasional failure may become a permanent psychic impotence through the underlying mental fault and auto-suggestion.

Temporary psychic impotence is found mostly in the highly organized type of society, among superior men, when there is want of responsiveness by the mate. Only the low and vulgar can use force and associate with an unwilling mate, the superior men are by nature passivists. In the preliminary sex play in such cases the female has to take

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the initiative in the necessary petting, toying, caressing, etc. Sanctimonious frigidity will not call out his virility. If for squeamish sanctimony she assumes the attitude of "serve yourself" and refuses to perform her share in the preliminary rites, her behavior will induce dissociation and will not call out the virile priapic attitude. The "serve yourself" posture, where the supine position and the femoral divergence are the only contributions wrung from the hypocrisy of the mate, may suffice for the common dull people to whom the overtones of sex are unknown and with whom the mere presence of the female makes an instant appeal to their virility. These individuals mate on a simple physical basis like the animal; and respond to the slightest stimulation. But the intellectuals mate more or less on the basis of intellectual attraction; and intellect is still young, scarcely a few thousand years old, the instinctive paths are not yet well leveled, smoothed, and planed. Icy frigidity which repels even the common man, therefore, makes the superman's sex relations entirely impossible. The more cultured and sensitive the man is, the greater will be the disturbance in the consensualism between stimulation and erection. If the female throws obstacles in his way, his volupty, potency, and pleasure tone of the libido will be greatly modified.

Such men may resort to extramarital miscegenation, to the transient unions of the lupanar where the oversexed dispensers of pleasure barter their sex for a consideration,

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and craving libidinous experience for themselves, have trained themselves to receive and bestow somatic satisfaction on the most timid and diffident. They know how to encourage, urge, and stimulate even the highly organized men who cannot serve themselves. The result is that such men are relatively impotent in their marital chamber and perfectly normal in their transient unions. On the other hand, there are men who are impotent just in company of the venal woman through the anaphrodisiac of fear of infection.

Extreme excitement after long abstinence may cause temporary impotence. The expectancy and joy over the final reaching of the goal causes a great nervous disturbance within the inhibitory centre which becomes overexcited, and at the critical moment the erections fail, the penis becomes flaccid and shrivels half its normal size.

Romantic men with their overvaluation of the female character may find themselves temporarily impotent from sheer nervousness through the obsession of shame, associated with modesty and timidity. In the subconsciousness of the romantic man there is still lingering a certain awe and reverence towards the door of life, transmitted from the remote period of yonic worship. This door has still a symbolic anagogic significance for him. This part of the female anatomy is still taboo; it must not be seen, touched, or even thought of by an outsider. So every boy is taught in home and school, and it remains a complex in his subconsciousness in a generic sense. This awe may act as an inhibition against the required impulse which ought to

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start from the brain centre to the centre of erection, when the newlywed approaches his young bride.

This same man would find little difficulty in the association of the woman of easy virtue. The latter is considered a public comfort station, a privy, where he discharges the contents of the seminal vesicles, just as he discharges the contents of the bladder, without giving any thought to the receiving channels. Most men do not care much for the looks of a privy, any place is good enough for them. Some men are more fastidious and rather particular, and gladly pay a considerable price for a beautiful, ornamented, and scented environment. The beautiful object may have even a certain charm for them for a while, and then it is dismissed out of the mind and forgotten. Thus, with the woman for whom he has none of the higher feelings, he is perfectly potent.

¹⁰Stekel, in his book on psychic impotence, brings out several points worthy of consideration. He believes that the inhibitory and aversial influences may begin and end in the preparation for the act, as when there is a conflict with another sexual drive (fetichism, homosexuality) which blocks the normal wishes; during preparation for a normal advance (a restraining phobia); then at a stage of closer contact (forgetting a rendezvous); then on being together; then with the preliminaries for coitus (sudden indisposition); anxious bashfulness about nudity; then in the form of an insufficient or absent erection when libido is present, is vanishing, or has changed its direction; then directly

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before the eleventh hour, as *ejaculatio ante portas* or as *ejaculation praecox* after successful penetration, and finally, as if to undo all preparations, as an absence of orgasm.

Stekel believes that the majority of patients whom one observes are those with relative impotence, persons who show waves and fluctuations of potency on different occasions and with different women. In the extreme, more rare form, that of paralytic impotence, the power of erection appears to have been entirely abrogated or is confined to a small degree of function. In rare cases, speedy erection occurs and forthwith disappears; in most cases there is only a slight enlargement of the organ; in intermediate cases there occurs a *semierrection* which makes introduction of the organ impossible. When the power of erection has entirely gone, morning erections are absent. The seminal emission follows with more or less strong orgasm, though this at times may also be entirely absent, the organ remaining flaccid. With the organ flaccid, the man may ejaculate on kissing or embracing a sexual object in a dream. This form of impotence may occur in homosexualists, fetishists and in some persons even on reading sadomasochistic literature. All these cases are only a variety of *ejaculatio praecox* and like the latter are conditioned by psychic inhibitions. In them one observes, as an expression of oncoming recovery, that the patient will have erections without coming to an ejaculation.

Before taking up the question of the etiologic factors proper involved in impotence, Stekel first disposes vigor-

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ously of certain fallacies which he believes are still widely prevalent among members of the medical profession. There is a notion current among many that the greater the excess the sooner will the natural power be lost, and that early loss of power in civilized man is essentially due to his excesses. Accordingly, all kinds of advice are given. This fairy tale about the need for gentle treatment of the procreative force and the blessings of moderation is nothing but a myth. As a matter of fact, quite frequently, perhaps universally, the very persons who give scant consideration to the preservation of their potency maintain it to advanced age, where as those who are economical about it frequently lose their full sexual power prematurely. A frequent observation is that persons endure so-called "sexual excesses" much better than total abstinence; while the "sexual" constitution certainly plays a role, the psychic factor is of greater importance than the constitutional. Above all, the most important factor is the power of inhibitions surrounding the sexual impulse. No one whose sexual act is accompanied by fear and inhibition can unfold his entire sexual power. Neither abstinence nor excess results in "physiological impotence". When the particular requisites for potency are fulfilled, potency returns.

What has been said of sexual excess and abstinence as etiologic factors in impotence hold true also of masturbation. Popular and scientific books maintain the false notion that masturbation causes premature impotence; the physician, instead of being a healer, becomes a moralist and preacher.

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There are many victims of such literature on masturbation.

If it were true that masturbation is responsible for impotence, why should the ill effects of masturbation make their appearance after many years of health? There are many instances in which auto-eretic practices did not leave harmful results until the person, from one source or another, gained the idea that the practice would be followed by horrible consequences, of which impotence is one.

Contrary to the prevailing notion, masturbation in itself is harmless and does not have an effect on or relation to potency; the same is true of pollutions. To appreciate it adequately, one must realize the force behind the practice of masturbation. When a paraphilic person masturbates, a seemingly complete impotence may appear after masturbation, not as a result of but as an expression of inhibitory processes against sadistic, necrophilic or other paraphilic fantasies accompanying the sexual act. The coincidence of the phenomena need not be interpreted in terms of cause and effect; they both may be the effect of another cause. There are men who have masturbated excessively for fifty years and are still potent. On the other hand, there are instances of recent impotence in persons who have never masturbated. It is known further that children of chronic masturbators are often in remarkably good health. Their masturbation was only a substitutive act and was not done against inner resistance.

The clinging to an infantile impression is frequently found in masturbation or impotent men. The power of erec-

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tion and the traumatic image remain permanently associated; one becomes conditioned on the other. Many persons masturbate with particular picture of fantasy in mind; and it is this accompanying fantasy that furnishes the driving force behind the indulgence in the practice.

Pollutions likewise do not reduce sexual powers. They are a sign of a violent, ungratified sexuality; they are, in fact, always masturbatory acts, occurring, however, in the absence of consciousness.

While it is true that many onanists are impotent, this is because they are paraphiliacs, persons whose sexual aim is not a woman or who seek some form of gratification which is subject to veto--sadists, masochists, urolagnists, homosexualists or passion murderers. Gratification is obtained because there is always a "specific pleasure-arousing fantasy" associated with it. When masturbation serves as a substitute for the normal act, it may easily be given up and is not associated with much pleasure. Other persons receive greater pleasure from masturbation than from the ordinary sexual act because masturbation protects them from paraphilias. Immoderate masturbation practiced to advanced age, impotence and excesses are in themselves symptoms of, and self protective measures against asocial and atavistic impulses. Masturbation thus fulfills an important social function; its suppression would increase the number of sexual crimes.

The impotent person excludes himself from reproduction

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as long as he considers himself unworthy and incapable of it. Sadism has always been an enemy of civilization, and sadists who are afraid of themselves must paralyze the sexual impulse. One can thus appreciate the terrible punishment which conscience places on a pleasure the justification of which has been forfeited. The union of hatred with absolute potency creates the sadist, the passion murderer, the sexual criminal. The amalgamation of hatred and impotence is an expression of a curative tendency, and under proper guidance can be cured. Genuine love can redeem these patients.

After these preliminary considerations, attention may be turned more specifically to the nature of the inhibitory psychic factors that stand in the way of realizing full potency. Unconscious loves and hatreds are prolific sources of impotence. A person who whether for social or economic reasons or as a result of pressure from the family, marries not the girl he loves, but another, may find himself impotent in marriage because his feelings are elsewhere. Another instance is when a man is obliged as a duty to marry a clandestine lover and react with impotence. An unconscious or even a fairly conscious hatred of the wife, over critical attitude of the wife and unrecognized jealousy may also result in impotence. However accidental the expression of impotence may be, its cause is placed elsewhere--past excesses, masturbation, and the like. Through a sense of guilt, arising from various sources, this impotence comes to be acknowledged as a weakness brought about by sins of the past.

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More than that, in every case of impotence one must seek a secret love requisite on which adequate potency seems to be conditioned; the patients, however, either hide, or are unaware of their fantasies. These prerequisites may be peculiar, absurd or bizarre: a particular dress, a particular reaction may be specifically required of the partner; stimulations of various parts of the body, from touching to flagellation and physical injury (real or pretended); various paraphilias---fetishism, pluralism, voyeurism. Most of these are conditioned on infantile experiences that have become fixed. Erotic symbolism often lurks behind loss of sexual power; it signifies that sexuality has become fixed and womanhood is renounced.

Relative to disorders of the orgasm it may be said that orgasm is an exceedingly sensitive reaction; a change in it may sometimes be the first manifestation of a disorder in the love life. The strength of an orgasm may vary from a feeling of tickling, associated with a pleasurable sensation, to such profound experiences that the individual groans with sexual pleasure, becomes confused and even loses consciousness; epileptic attacks have occurred following orgasm. The orgasm varies with age, with the nature of the sexual object, with the mood and frame of mind and with the fulfillment or lack of fulfillment of specific love requisites. Such disorder may show itself in gradations that run somewhat as follows:

1. The orgasm is pleasurable, but is either accompanied or followed---perhaps the day after---by different

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degrees of unpleasant sensations, pain, paraesthesias, fatigue, disgust and anxiety, which may sometimes be so pronounced as to make the patient renounce coitus because he is afraid of the pains. The pains are diversely localized, now in the occiput, now in the legs, but mostly, however, in the spinal cord (as if the entire cord has run off). Similar pains in consequence of autosuggestion are observed after masturbation, which is mistakenly interpreted by the physician as an objective proof of the injurious power of masturbation. With disturbance in sex relations already present, the physician confirms to the already anxious patient the injuriousness of coitus and recommends further limitations of sexual pleasure. Often, coitus aggravates symptoms that were already present. A neuralgia may become worse after each coitus; gallbladder pains may recur regularly, and myalgia may directly increase beyond endurance after coitus. An intractable vertigo, sometimes diagnosed as due to arteriosclerosis, often has the same origin. Instead of pains in the legs there may be weakness in the legs (hysterical paresis). Often these symptoms are assurance against an impulse to obtain tabooed pleasure. The pains may be due to abstinence and to moral inhibition. The "inner negation" expresses itself in pains which enforce virtue.

2. All feeling of pleasure is absent, but in its place is a more or less intense pain which is usually localized in the glans, though it may also radiate to the perineum and display the character of testicular pain. An instance

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is recorded of a person whose coitus with his wife was accompanied by intense pain which arose because, during intercourse, he indulged in incestuous fantasies about his daughter, and the reality itself amounted to pain.

3. The ejaculation is strong, but the orgasm is markedly reduced, as is the power of erection, which, in comparison with the former, acts with less rapidity and obeys the libido less promptly; copulation, it is claimed, is agonizingly tasteless and is followed by ill humor.

4. The ejaculation occurs without orgasm; the semen flows off without the characteristic feeling of pleasure. The anticipation of pleasure is followed by disappointment.

5. After long coitus (often an hour) a weak orgasm is forced (ejaculatio retardata).

6. Orgasm occurs with ejaculation (rare).

7. Despite hours of effort, tormenting anticipation and the feeling that the orgasm is due within a couple of frictions, it does not come; bathed in perspiration and exhausted, the patient gives up all effort. Sometimes these patients may force an ejaculation that is associated with a weak orgasm or one in which the orgasm is entirely lacking and with the substitution for it of an unpleasant feeling of even an intense pain. It is characteristic that these men consider themselves impotent; they have no confidence in their potency, erection does not occur and coitus is impossible. In others, after several movements ejaculatio praecox sets in and may also take place

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without orgasm. Indeed, fluctuation between ejaculatio praecox and ejaculatio retardata et sine voluptate is really the rule; these men are now impotent, now semipotent, now apparently very potent.

Among impotent men one not infrequently finds persons who have a semierrection, sometimes quite constantly, from which, because of accompanying fantasies, they draw so much pleasure that the orgasm of the end pleasure becomes superfluous.

In one case the patient was emotionally dependent on his mother, who exacted a vow from him that he would never have sex relations until after marriage. He broke the vow, and this became an etiologic factor in his psychic impotence. Sometimes it is an oath sworn on the life of a dear relative or in a church, or a promise given to some one on a death-bed, or even a false oath. Such a promise as: "As long as you are faithful to your wife, your children will not die" if broken, will result in a man consciously upholding his virtue by withdrawing the pleasure premium of sexuality, an orgasm.

All these reactions are only protective measures against the domination of sexuality, mostly unknown to the person himself, which, for one reason or another, he cannot realize in his partner. Thus, a man who has very cruel sexual instincts (beating, strangling or stabbing the sexual partner) may be able to maintain normal coitus of long duration without being able to attain an orgasm. When the specific sexual situation desired can be produced in an unglossed

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or even in a mild form, the orgasm will appear rapidly. This will explain why the man can be impotent with one woman and potent with another. Persons who suffer from ejaculations without orgasm and react to a discussion of homosexuality with disgust, aversion or vomiting, are themselves only disguised homosexuals.

Some men are impotent because they fear that with the experiencing of pleasure they might become enslaved to womanhood and thus be forced to be submissive; it is often an expression of the struggle between the sexes. Even when such a man maintains loudly that he loves the woman, his impotence speaks to the contrary. All neurotic patients suffer from excessive hatred which they desire to convert into love; hence, their eternal longing for love which verifies their inability to love. Under the influence of psychic tension love with them can be converted into hatred, and this love deficiency is betrayed by impotence or dyspareunia as the case may be.

In the case of absence of orgasm, as recovery takes place there will be first an ejaculation without orgasm; soon afterward the orgasm comes timidly, gradually growing until it attains its former strength.

That the marriage situation affects potency is a daily observation, and is further attested by clinical experience. Occasionally one observes that on marriage a young man goes on a regular orgy and finds himself in possession of sexual powers which he had never suspected and which he is not likely to equal or even approach in any future situation.

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A number of factors enter here, of which the overestimation of the love object, long courtship and the sanctioning of sex relations such as marriage gives unfolded potency to its maximum. On the wedding night men are seldom heroes; impotence and ejaculatio praecox are present in more than half the cases, for which rationalizations are not lacking (sparing the wife, etc.). Soon, however, there is better adjustment, but as the attractive values of the wives become reduced, there is also an apparent lessening of libido and reduction in potency; in extramarital relations these men show increased potency. Many men fear marriage and defloration because of repressed sadistic motives; others see in the bride an image of the mother or sister and fear to face the situation. One then may have impotence with the consummation of marriage.

Potency may be conditioned on passivity - the patient wants to be taken; marked masculine aggressiveness may also make the same patient potent. This requisite for potency may be an expression of childhood. Some men are afraid of marriage because some women display great resistance to it. Failure to meet this demand often drives married men into extramarital relations.

Impotence may arise in the course of the struggle between the sexes as a result of humiliation, as a protection against sadistic tendencies, and potency may return with victory over the partner. Cases of impotence arising in marriage, especially during the first weeks, can be cured if treated at the onset. The attitude and behavior of the wife

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usually determines whether the impotence will become permanently established. With marital difficulties, the sadistic component of the sexual impulse emerges into hatred; with this, potency vanishes as a rule.

Sometimes potency returns after the death of the wife, the father, the mother, or others. A man had a tendency toward passion-murder, to strangle his wife during coitus; he dared not to be potent--impotence was merely a protection.

Contrary to the view of Hohman and Scott, Stekel believes that impotent men should not be warned against marriage. Many impotent men become potent only in marriage; they are moralists with an innate hidden morality, which considers extramarital coitus a sin, which is practiced only under severe inner resistance. Some of the best husbands are to be found among men who have been impotent; such husbands are grateful to their wives. Among impotent men who are single one will find some who are apparently free from all inhibitions and who have sought gratification from prostitutes in vain; they have found themselves either impotent or semipotent; they have had liaisons with girls and have failed completely. Such men have a secret inner religion and struggle unsuccessfully against inner inhibitions. In all such cases one will never attain any results by recommending extramarital coitus, nor, as elsewhere, are drugs or other methods of any use.

Impotence in relation to other neurotic manifestations is interesting. It is the expression of the inner self, of

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the unconscious "I will not" which is behind the conscious "I cannot". Ascetic tendencies conceal their religious origin with all manner of esthetic and hygienic masks. If a marked sense of guilt becomes united to an ascetic tendency, there arises the colorful symptomatology of a sexual hypochondriac.

The feeling of inferiority, so universally present in neurotic persons, manifests itself in the impotent man in a variety of ways--he is ugly; he cannot please women, etc. From fear of defeat he takes refuge in impotence. In the hypochondriac, abstinence, anxiety and a sense of guilt manifesting itself in hidden reproaches and ascetic tendencies are prominent. A transition to these severe cases is formed by those ostensibly clumsy and innocent men who behave "like boobs" with women and are unable to consummate intercourse on account of awkwardness. Often they are latent homosexuals who really seek the anus. The play comedy before themselves and the woman in order to spare themselves and sexual fiasco.

Some fear the sexual act or, though still potent, fear that they will lose potency; to them this is a good reason to avoid marriage because they would beget only a sickly progeny. They may fear that every sexual act will shorten life; after one coitus they are exhausted and reproach themselves severely because inhibitions, temporarily overcome by the impulse, have flared up again. In many persons who are abstinent for some time there is a slight spermatorrhea at the end of defecation; it disappears with

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the resumption of sexual activities. Like all hypochondriacs, he anxiously economizes with his semen, as if it will help him to live longer. As time goes by, the genitals and their functions become the center of thought. These patients often drive the physician to despair. Suicidal intentions are as frequently expressed as not carried out. Analytic studies reveal that the hypochondriac zone is always an erogenic zone; that the hypochondriacal notion always arises from a sense of guilt, religious or ethical; that the moral dread of the hypochondriac becomes transformed into anxiety concerning the sexual act; that he avoids the physical act because it does not represent his adequate form of gratification. His anxiety is fear of a paraphilia which has been refused recognition in consciousness; therefore, he constantly oscillates back and forth between sexual desire and sexual anxiety. The anxiety is also anxiety for the final Judgement day which the hypochondriac is trying to forestall through self-dictated punishment and atonement.

It is interesting that in all these cases the patients do not believe in the possibility of a cure; they actually oppose recovery. Behind the disbelief in cure is a secret sexual aim which really means; "Possession of the desired person is the only thing that will make me potent. Since the law and my conscience are against it, and you cannot give that person, you will not be able to help me. If I cannot have the women I want, I will forfeit my recovery and

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renounce all women."

Interesting and significant is the neurotic person's reactions to the problem of time. From analyses it has long been realized that the attitude of the neurotic patient toward the problem of time is distinctly disturbed. Time, indeed, has little significance to him; to suit his needs he arbitrarily fixes a situation which prevailed many years before. Reality is often obstinately maintained and fixed long after it has ceased to be a reality. In the neurotic person, psychic phenomena are placed at the disposal of wish fulfilment. He wastes much time before accomplishing anything.

In contrast to the neurotic person who has lost patience and is tired of waiting is the opposite type, for whom waiting is a great pleasure; he puts off a decision in order to prolong the forepleasure, until finally the forepleasure becomes an end in itself. The neurotic person knows only the forepleasure of reality and the afterpleasure of memory. The person who is suffering from ejaculatio praecox is already satisfied with the forepleasure; in sex relations, a man who is potent is also a man who can wait.

The problem of time is mingled with that of impotence. There are many cases that illustrate how the neurotic person plays with time during coitus. Those who manage time like a valuable possession have time for everything and therefore also have time for love. The time in love is never lost, for it is regained through enhanced productive energy.

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Whoever does not allow himself time for love because he loves time will eventually flee into a neurosis that will disguise the love inadequacy.

In surveying large number of mentally disordered individuals, one encounters, not by any means infrequently, those who are imbued with the idea that they are incapable of properly effecting the act of cohabitation. Freud has stated that if he were asked with what one situation the psychoanalyst is most often confronted in dealing with the neurotic he would reply, psychic impotency. E. Jones makes a similar observation. Similarly, in the psychotic, the psychopathologist comes upon the identical symptom-complex daily, though often, in a disguised form. Freud feels also that psychic impotency, in the broad sense, accounts for civilized man's deference toward women.

The method by which we determine the origin and development of this phantasied sexual inadequacy and show its very intimate, if not identical, relationship to the evolution of the mental disorder may be described purely as a correlation between the cross-section of the psychosis itself (with special reference to the content) and the longitudinal panorama of the interreaction of the individual with his environmental stimuli prior to the development of the psychosis. In other words, the development of the psychosis, in many instances, is nothing other than the development of the psychic impotency. We discover that the integration obtained may be exposed with greater efficiency and lucidity

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in the psychotic individual who is normally wont to speak his thoughts without that restraint which so often obscures the mechanism in the neurotic.

The subject of sexual impotency in the male has been approached clinically from several angles, but the subjects studied have been merely neurotics, rather than psychotics. The more outstanding of these perusals have been effected by Freud, Stekel, and Maxim Steiner. The last mentioned gave due credit to both Stekel and Freud for their having demonstrated the general source of the difficulty. Freud in his collected papers duly emphasizes that many of the psychopathological entities result from the phantasied impotency, when the individual finds the adult heterosuxual obligations not only uninteresting but often intolerable. This is due, he avers, to the fact that the libido becomes fixated upon the mother or sister or other preadolescent love objects and is hence not free to become attached to heterosexual ones. Alluding to the sexual instinct, he says: "When we think of the long and difficult evolution the instinct goes through, two factors to which this difficulty might be ascribed at once emerge. First, the consequence of two thrusts of sexual development impelling toward choice of an object, together with the intervention of the incest barrier between the two, the ultimate object selected is never the original one, but only a surrogate for it..."

Steiner classifies psychically impotent neurotics into three categories: (1) Those afflicted with inferior constitutional sets, (2) those deterred in preadolescent

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sexual development through obnoxious familiar influences, (3) those developing impotency concomitantly with the onset of senility. He likewise calls attention to over-sublimation as having a certain bearing on the occurrence of psychic impotency.

¹⁰Ernest Jones, in giving a very complete survey of the subject, mentions Freud's theory regarding the failure of the sentiments, of tenderness and sensuality, to become properly fused; to go further, he offers two additional factors which predispose to psychic impotency. These are: (1) Fear of punishment for sexual activities, (2) the tendency to associate the female genitalia with the organs of excretion. Adler expresses the opinion that "there is no organ inferiority without accompanying inferiority of the sexual apparatus." We assume that he means inferiority of the sexual soma and consequently not subscribe in toto to this very broad assumption inasmuch as several of our psychotic cases before the onset have been extremely fertile, and upon the initial physical examination have shown marked evidence of inferiority in several organs. When he postulates the "masculine protest," he comes very close, it seems, in a rather vague way, however, to arriving at an adequate solution of the whole problem of psychic disintegration.

¹⁰Stekel's observations have run along the same line as the discoveries of Freud, and as described in Steiner's second category of cases; to wit, frustrations in the normal sexual development due to excess energy outflows toward love objects encountered in the different stages of meta-

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morphosis seem to account for the inadequacy. Starke goes further in deciphering the intricate mechanism concerned in the synthesis of this ultimate sexual incompetency. It is his theory that not infrequently, especially in cases that have been overweaned or improperly weaned, the loss of the nipple gives the infant such a marked sense of bewilderment and desertion that the vestige of this affect lingers even up to the heterosexual stage, when the adolescent persists in the obsession that he is worthless sexually. We do not imply, of course, that the infant at the weaning stage actually experiences what is known to the psychiatrist as psychic castration, but the remnants of this infantile feeling are eventually crystallized into a psychosexual impotency complex in the later stages of preadolescent sexual life.

The explanations alluded to in the last paragraph are all important and are indispensable as explanatory factors in the subject of psychic impotency. It fell to the lot of Otto Rank, however, to pave the road to something like a coherent and complete approach to the problem. By reading his very lucid account of the normal sexual metamorphoses, one may glean the possible pitfalls into which the individual may stumble in the course of sexual development, which may imbue him ultimately with spurious notions of sexual inferiority which have no organic foundation.

According to Rank, the institution of weaning necessitates a search on the part of the infant for a sub-

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stitute upon which the strongly charged oral libido may feast itself. The penis offering great similarity to the nipple and being in suitable proximity on the child's own body, a sort of vicarious nursing process ensues in which the penis is substituted for the nipple and the hand displaces the mouth; thus masturbation. If this first step is incomplete or is obstructed in any way, the libido will most likely remain fixed at the nursing level.

Mother identification may occur, along with the castration obsession as an additional result. Normally, however, through masturbation and the accompanying appearance of self-love, the fear that the nipple deprivation meant emasculation becomes transferred into a sado-narcissistic urge to become independent and thus avenge the maternal desertion; the homosexual stage is thus attained through narcissism and accompanying effort to find an object like one's self.

This step having been accomplished, the child then beholding his father as the cause of his troubles, is unconsciously compelled "to beat him at his own game," so to speak, and thereby seek another revenge and attain, as a consequence, the heterosexual goal.

The groups of psychically impotent psychotics following the sequences of sexual development so succinctly delineated by Rank are:

Group I. Those traumatized at weaning

(a) Those who through compensatory substitution become either latent or active homosexuals as a result of the trauma.

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(b) Those who remain sexually, though not necessarily intellectually, at the nursing level and never pass through other stages of the same cycle described by Rank.

Group II. Individuals libidiously fixated to pre-adolescent love objects on a fashion latently incestuous.

Group III. Individuals sexually traumatized through inadvertent preadolescent sexual indulgences of incestuous nature.

Group IV. Those whose love energies are dissipated in avenging imagined parental desertion or neglect.

(a) As a result of death of parent of opposite sex.

(b) Due to jealousy of parent of opposite sex (Rank mechanism).

PSYCHIATRIC TREATMENT OF IMPOTENCE

¹⁷ Before attempting to discuss the treatment of psychic impotency, the palliative psychiatric handling of cases of incurable impotence will be mentioned.

To a man of intelligence and education one may point the way to higher things with greater compensations than mere sexual gratification. One can say to such a man, "it is true that life at the sexual level is finished for you, but a larger life lived on a higher plane may be just beginning. Point your vision higher, not necessarily to dreams and the stars, but to life with the poets, with the immortals of literature, art and travel, writing, painting, religion and its mysteries and comforts,

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and philosophy, which should be the final goal of all intellectual peace. You may live your life for service to your immediate circle or to mankind generally. Research of all kinds is open to you and freedom from the demands associated with living life at the sexual level will leave you more time for productive work. There are before you many paths leading to peace. Why, therefore, regret the passing of an appetite?" To a man with acceptable, intellectual endowment and education this viewpoint will be as a breath of a new life. On the other hand, what can one offer to the man who is capable of living only on a lower plane? Many men glory in the fullness of all their appetites and physical powers and sex is the king over all. It must not be forgotten that perhaps a majority of men in the general population still make sexual vigor the standard by which manhood is measured. The descriptive words, "loss of manhood," are still used to denote sexual impotence. Loss or deterioration of this power is a crushing blow to the ego of these men. They become sensitive and the emotional reaction is often profound. Loss of sexual power often leads to chiding by the mate, and to sneers and hurtful digs from those who learn of its existence. This is followed by anxiety, depression, agitation and often a prolonged flight into a psychoneurosis, or even deeper, into a psychosis. One might begin by interviewing the wife of an impotent man of this type. She must be cautioned not to chide the husband. If anything she must be more gentle and kind than

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before. She must be careful not to sneer or be critical or to change her behavior so that the spouse may not fear that he has lost his caste with her. Not a single word or look to convey the thought that she loves him less. These couples should be advised to live in separate rooms, at least until the tension growing out of the situation has eased. A gradual development of interests outside themselves is desirable. Religion is often a comfort. The development of a hobby will often help. Exercise in the form of strenuous games will often be very satisfying. If the desire persists in the face of impotence, and unfortunately it is under these circumstances that increased desire occurs, then the use of bromides is a very desirable thing.

¹⁰
Most cases of impotence are determined not organically, but functionally, according to Stekel. The exceptions are those for which the palliative treatment has just been alluded to (lesions of the spinal cord, diabetes, hermaphroditism, etc.). If this be true, then all forms of mechanical, medicinal and surgical measures must fail, and that psychotherapy offers the only reasonable approach. Simple suggestion, mechanical intervention, electrical procedures, cold water cures, special diets and all aphrodisiacs may be effective not per se, but because by suggestion they create the idea: "Now, everything will certainly be all right," which overcomes the inhibiting idea. There are cases, nevertheless, in which these therapeutic attempts

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are absolutely powerless.

As for ²²psychotherapy, it must be borne in mind that false psychotherapy may do injury by nursing a "feeling of illness," which in impotence is the disorder itself. This usually comprises a combination of analysis, suggestion, and emotional and environmental readjustment. In many cases complete relief is afforded easily by a superficial analysis. In others it results after a profound study of the patient's subconscious life, for often he is quite unaware of the existence of trouble-making complexes that lie deeply buried in the subconscious realm of his mind.

⁶In the correction of impotence, as well as in the prevention, it is well that the physician be highly informed concerning normal sexual physiology. It is unfortunate that the curriculum in most medical schools does not include any education in the sex physiology of intercourse. Every physician should be prepared to give sympathetic and technical information to young people who are about to be married. The information which they receive from friends and parents is often inadequate and incorrect. One cannot count upon instinctive desires to establish correct technique. Frequently the mishandling of the early sex experiences in marriage, permanently ruins the chance for satisfactory sex adjustment. The difficulty in rupturing a resistant hymen, the difficulty in having intercourse through too narrow vaginal outlet, the failure to have prompt and proper lubrication, are problems frequently met with, and do

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great damage when the married pair are not prepared and instructed. The pain resulting for the woman turns her against sexuality, and the man is apt to develop serious feelings of incompetence, because of his inability to make the sexual act simple and not painful. Frequently the use of some lubricating jelly will solve the problem completely. We might justly urge every woman to consult a gynecologist before marriage in order to determine whether any undue difficulty was to be encountered. Self consciousness about such examinations must be abolished.

¹⁷
In mild cases with the mechanism not so clearly present, especially occurring in married people, the causes are often easily remedied. Intercourse performed under the stress of fear of inducing pregnancy or of being discovered, the apprehensive attitude of the economically harassed husband, the too prolific wife, all these are frequently causes of sexual impotence or weakness. After varying periods of contraceptive measures taken in this spirit of fear, either husband or wife, or both, may find themselves impotent or frigid. A long separation from bed, if not from bed and board, with finally proper birth control instruction and technique, is the plan of the treatment indicated here. Even without fear, withdrawal practiced over a long period of time frequently induces loss of sexual appetite and desire. The reaction of the man or woman of fine sensibilities to this measure may result in a revulsion of feeling toward the act and finally in frigidity. Much the same mechanism

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occurs when the husband finds his wife is careless about vaginal cleanliness, particularly, though some women seem to get generally slovenly after marriage. Lastly, frequent spats and downright quarreling dull the appetite and occasionally result in obstinate impotence till a new love mate is found. The indications for treatment in these cases are plain and frequently as successful as they are clear.

¹⁰The more recent the onset of impotence, the easier is the cure. Even a single explanation may work wonders; the less such patients are treated, the better, because every treatment enhances the "feeling of being sick" and has an inhibitory effect on the patient. Secretely, many patients do not wish to be cured. At the same time it must be remembered that rapid results cannot be forced; such advice as to visit a prostitute most often brings only transitory relief. Should a person come to the idea "I am impotent," it will in itself act as a pernicious autosuggestion. On the next attempt at intercourse the idea appears before the act; doubt and fear of ridicule will automatically act as still stronger inhibitions. In such cases the prognosis will depend on whether in any situation the fear and doubt are stronger or weaker than the object that stimulates the libido.

²²The prognosis is ordinarily excellent with younger men, is less bright as age advances. A large percentage of all cases respond perfectly to treatment. Others gain only partial improvement, and a few are incurable because of practical impossibility of altering certain factors in the

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personality or in the environment.

UROLOGIC STUDY**ETIOLOGY

Before taking up the study of impotence from the viewpoint of the urologist, a few words will be directed toward the physiology of erection and ejaculation.

Both are under control of the nervous system. Centers are stimulated in the brain and in the lumbo-sacral region of the spinal cord. The cerebral center is the seat of sexual impulse and appetite. The lumbar center regulates the mechanism, through nervi erigentes, which pass from this center to the sexual organs. The glans penis has an abundant supply of sensory nerves which transmit stimuli backward to the sexual center. Stimulation of the nervi erigentes produces erection.

Normally both centers act in unison, but they can act separately, for it is a well established fact that one can inhibit erection by mental effort; it is presumed that this is accomplished by inhibitory nerve fibers passing from the higher centers to the lower ones. For normal coitus erection is essential, and this is produced by vascular engorgement of the erectile tissue, obtained through stimulation of the nervi erigentes, the erection being maintained sufficiently for complete coitus by compression of the efferent veins thru muscular contraction. Stimulation of the cerebral center, by impressions conveyed through the senses, sight, touch, smell etc., evoke erection, which is also maintained through the spinal center, as in

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diseases of the spinal cord and external genitals, erection is incomplete or lacking. It has been proved that there is a distinct spinal center for ejaculation independent from that for erection, and this explains certain cases of impotency in which emission occurs with erection.

So much importance is attached to the posterior urethra and surrounding structures that a brief resumé of the anatomy of this region is in order. The posterior urethra is that portion between the anterior layer of the triangular ligament and the bladder. It is about two inches in length and includes both the membranous and prostatic urethra. The prostatic portion is the widest and most dilatable portion. The canal is somewhat spindle shaped, being wider in the middle than at either extremity. It extends from the bladder to the membranous urethra, and runs vertically through the prostate gland.

Upon the posterior wall of the prostatic urethra is situated that very important structure, the verumontanum. This is about 13 mm. in length and about 3 mm. in height, although these measurements vary greatly in different individuals. It probably affords a crest upon which the ejaculatory ducts may open. The prostatic ducts open on the floor of the urethra, and converge toward the veru. During ejaculation, therefore, this arrangement brings about a complete intermingling of the thick gelatinous semen and the thin prostatic fluid from the ducts, thus causing a homogenous fluid, which enhances and preserves the vitality of the spermatozoa.

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It may be hard to realize, for one not experienced in posterior urethroscopy, especially in the urethroscopic picture of the so called sexual neurasthenic, what tremendous symptomatic effects may result from apparently slight pathological changes. Those who expect to find gross pathological lesions in the posterior urethra in such markedly perverted conditions as impotence, masturbation, and the like, will often be doomed to great disappointment. After much experience they will finally realize that a slight congestion in the region of the veru, a congestion which is often overlooked or considered trivial by the inexperienced, may be, and very often is, the cause of the gravest symptomatic consequences.

Let us now consider the relationship of the posterior urethra to some of the more common disorders of the sexual function. Masturbation is probably the most widespread disorder.

The pathology of the condition is in brief as follows: Through some accident, due perhaps to a tight prepuce, to smegma or other local condition, the child manipulates its penis. This first manipulation may be done without any thought of sexual pleasure, or it may have been taught to the child by older boys. Whatever the cause, this manipulation of the penis sends an impulse to its brain, which, as in ordinary coitus, sends an impulse to the muscles of erection, and also determines an increased blood supply to the prostatic urethra as well as to other portions of the genital tract. So far the condition is like ordinary coitus.

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But this act frequently repeated leads to a permanent hyperemia of the prostatic urethra, so that impulses from here are being constantly sent to the brain, which again in response sends continuous sexual impulses to the prostatic urethra and adjacent sexual organs, thus increasing their congestion still further. A vicious circle is formed.

As the result of the practice of coitus interruptus or withdrawal over a long period of time, there results an intense congestion of the posterior urethra accompanied as a rule by swelling of the veru. There is at first a hyperirritability of the erection and ejaculatory centers in the spinal cord, so that, at this stage, ejaculation takes place at the very commencement of coitus, often before the penis has entered the vagina. Later there occurs a complete exhaustion of the centers, so that they refuse to transmit impulses to the genitals, and thus we get the clinical picture of impotence.

²⁸
In a series of 300 cases of impotence of varied types collected by Wolbarst, the following facts were disclosed on analysis: (a) 132 (44%) gave a history of previous gonococcal infection usually involving the adenexa. Of these, 89% showed intrurethral pathology.

(b) 82 (27%) practiced "withdrawal" for more or less lengthy periods (3 to 13 years). Of these, 81% exhibited intraurethral pathology.

(c) 43 (14%) admitted excessively frequent intercourse in their early years (arbitrarily set at more than thrice weekly). 76% intraurethral pathology.

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(d) 14 (5%) admitted frequent and long continued masturbation (more than twice weekly) for periods varying from 4 to 15 years. 63 % intra-urethral pathology.

(e) 15 (5%) admitted a history of ungratified sexual desire covering long periods (5 to 17 years). 73 % intra-urethral pathology.

(f) 8 (3%) have unmistakable evidence of endocrine dysfunction. 29% intra-urethral pathology.

(g) 6 cases presented evidence of psychic disturbance. 66 % intra-urethral pathology.

*Classification made on basis of predominating factor.

From the above it is concluded that abnormal sex living and gonorrhoea undoubtedly are the most common causes of impotence.

It is easy to explain the pathologic lesions in the posterior urethra in the cases that have had gonorrhoea; but how shall we explain the presence of a pathologic veru or urethra when there has been no urethral infection? And why on the other hand do we find no gross pathologic changes in cases with a positive gonorrhoeal history?

It is generally but erroneously assumed that the pathologic veru is the fundamental cause of the functional inadequacy; therapeutic attack therefore, is directed to this organ.

In the average case, it is true, an appreciable improvement in the sex function may be expected from the local treatment thus applied to the veru and the urethra and their restoration thru decongestion to the normal.

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On the other hand, we are often confronted with cases which make little or no response to lengthy courses of intra-urethral treatment. In the latter cases, it is probably because we have made the common error of concentrating our therapy on a symptom rather than on a primary cause. In other words, the pathologic veru we see thru the urethroscope instead of being the actual cause of the impotence is rather but one subjective symptom of a distant but related pathologic condition, a subjective symptom of which is impotence.

In the same degree that the gastric function may be upset by a disturbance elsewhere in the intestinal tract or in more remote parts of the body, it is reasonable to conclude that the sex function similarly may be disturbed because of dysfunction in the genital tract or elsewhere in the body. This dysfunction may manifest itself primarily in the endocrine chain, in the nervous system or even in a general disturbance of metabolism, all of which may be reflected in an impairment of sexual function.

From this angle, we may consider the distortions and inflammations in and about the veru as the visible reaction of that organ to some obscure factor in the sex mechanism, or in the nervous or endocrine systems, which serves to bring about a functional deterioration in the sex centers. To counteract this deterioration it is quite plausible that the congested veru, because of the strain placed upon it, may and does undergo a compensatory reaction, analagous

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to the compensatory hypertrophy of the single kidney remaining after nephrectomy. What we see through the urethroscope is thus the effect and not the cause of the sexual disturbance. If we were fortuitous enough to examine the veru before the sexual breakdown has occurred, we might probably find the organ and adjacent tissues but moderately altered, this being interpreted as the price the veru has been called upon to pay for "pegging" the failing sexual power up to that time. It is only when the debacle has occurred, when considerable or total loss of function has supervened, that we are called upon for relief, and we find the veru hypertrophied and distorted out of all semblance to the normal--hypercongested, bleeding easily, and the surrounding parts seriously damaged.

⁶
Hohman and Scott set down as criteria the following physical abnormalities as causative agents of premature ejaculation and impotence: Inflammatory conditions of the prostatic urethra, verumontanum, prostate, seminal vesicles, and ejaculatory ducts. More specifically they require as adequate findings in verumontanitis pronounced enlargement, swelling, and congestion of the posterior urethral mucosa or the replacement of the covering epithelium by granulation tissue. It is probably true that, in addition, inflammation of the same degree of severity involving the region immediately posterior to the verumontanum may also produce sexual impotence. In addition to infectious inflammatory reactions one may also have superficial traumatic lesions of the posterior urethra, e.g., irritating calculi; foreign bodies

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introduced for erotic purposes into the urethra etc. Injury to the nerve supply of this region due to operative interference may at times disturb the mechanism of erection and ejaculation.

New growths of the prostate and posterior urethra may result in interference with sexual potency either as a primary cause or through secondary inflammation or ulceration. The symptoms resulting from the above pathologic conditions are either premature ejaculations, with or, more commonly, with bloody discharge and also impotence. It may be emphasized that these pathological findings may be present without actual interference with sexual function.

Inflammatory reaction involving the prostate gland may give rise to premature ejaculation and impotence by secondary infection in the posterior urethra and verumontanum. It is Hohman's and Scott's opinion that if prostatitis plays any role in the causation of organic prematurity of ejaculation, it is by the above mentioned process of secondary extension. It is important to bear in mind that the great majority of prostatic injections, even of the most severe grade, do not give rise to any symptoms. The idea conveyed agrees with that of Wolbarst when the anatomic status of the veru is interpreted correctly. ²⁸ He believes that there can be no doubt that in the cases where organic pathology is the clear cut predominating factor that the vesicles are the primary seat of the trouble, with the veru and posterior urethra merely reflecting the pathologic conditions existing in those sacs. There is

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considerable clinical and pathological evidence to show that the veru is in reality a continuation or antenna of the seminal vesicles and in the sense "the mirror of the vesicles," to use the term so aptly coined by Luys. Confirmation of this clinical connection is presented in the histo-pathologic study reported by Hyams, Kramer and McCarthy. It is their conclusion that the most reliable gross criteria of the probable presence of chronic seminal vesiculitis were found in the prostatic urethra. They found that chronic inflammatory pathologic changes were most frequent in those cases showing frank advanced sclerosis of the posterior urethra and vesicle neck, cribiform deformity in the region of the verumontanum and dilated, sclerosed, patent prostatic ducts with or without distortions of the size, shape and position of the verumontanum. They observed also that the size and consistency of the prostate were helpful only as they served to corroborate the impression of widespread chronic inflammation of the mucous surface of the posterior urethra and bladder neck.

¹³
Lubash reported that a cyst of the prostatic utricle caused impotence in a man 25 years of age. This cyst measured $2\frac{1}{2}$ by 2 cms. The condition was cured by catheterization of the contents of the cyst. There was no recurrence. This is a very rare cause of impotence.

¹⁴
According to Porpz, constant emptying of the sperm is prevented by the sphincter muscle of the seminal vesicle. This sphincter is interwoven with the muscle bundles of

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the prostate and stands in organic dependence upon them. If it is not sufficiently strong, rapid ejaculation occurs, and at the same time disturbances of function dependent upon the muscular activity of the prostate sets in. On these grounds the symptom group under "atony of the prostate" has been included.

The first striking symptom of this condition is dribbling of the urine at the end of urination instead of the normal sharply emphasized and sharply terminated expulsion of the stream. Where no other cause of this condition is to be found (stricture, stone, cystitis, etc.), then this symptom will arouse the suspicion even of the general practitioner. It points to an insufficient shutting off of the bladder. In fact, instead of the normal three to five urinations per day, there occurs an urgency which results in 10 to 15 urinations a day and from three to five per night. Often therefore, the sleep of the patient is disturbed. At the same time nocturnal pollutions appear, at first only after a short abstinence, but later more often, and in time these can occur every twenty-four hours. Some patients have two or three pollutions in a single night.

The appearance of accompanying dream pictures is characteristic in which connection it should be noted that the dream does not cause the pollution, but the dream is caused by the nervous stimulation which results from the pollution. With a normal prostate, sexual dreams of central origin occur without pollutions. Whereas the dreams

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of the abstinent are often of long duration and often complete an entire circle of increasingly erotic pictures; the pollutions dreams in men suffering from atony of the prostate are always short; they begin at once, as a rule, with the act without any preliminaries. The patient in his dream finds himself in an unknown place and among unfamiliar surroundings, along with any unknown woman. The ejaculation follows as when awake, during or before intromission. There are indeed far advanced cases in which the dream entirely fails.

After the pollution the patient feels himself weak and dejected, is nervous and ill tempered. Also often his efficiency is impaired.

In such patients one finds spermatozoa in the urine after straining at stool (defecation spermatorrhea). If the atony of the prostate increases, one finds spermatozoa in the urine after every defecation whatever. Seminal losses become more frequent and abundant. In this phase of the disease, pollutions are less common, and can entirely cease. The condition may progress to such an extent that a light pressure upon the abdomen or lifting of a small weight is sufficient to cause appearance of semen at the end of the urethra.

If the general health is not disturbed by the above mentioned symptoms and the reflex psychic and neurotic symptoms, many among them become resigned to their unfortunate condition. However, the great excitability and the easy

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liberation of libido often cause unbearable annoyance. Libido often occurs under very slight stimulation, and causes at first only embarrassing erections, which at the correct time either fail entirely or are slow and incomplete. This sort of libido becomes associated later with symptoms of nervous irritability, such as palpatation of the heart, trembling of the hands, feet or voice, blushing, etc. The patients can scarcely speak for embarrassment. These symptoms often appear a long time before coitus and can be cause by merely thinking about the act. The patients are altogether too much engrossed by sexual phantasies and even considerably handicapped in their daily work by their abnormal pre-occupation with erotic ideas.

In order to escape from this unbearable situation the patient seeks relief in intercourse. They are however disappointed in this effort. Erection fails in their nervous excitement, and even when it occurs, it all ends with a very rapid ejaculation. The atonic sphincter opens at once, and allows the ejaculate to flow out almost without obstruction.

With this, a low standard of orgasm, or even its absence is associated. Ejaculation does not occur in from four to six stages with interruptions, but all at once as the act of urination, without any sensation. The feeling of being unsatisfied which follows the premature ejaculation can in the early stages of the disease be modified by repetition of the act. If, however, this repetition is not possible, the

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unsatisfied feeling remains and the depressing psychic disturbance continues during one or two days.

In the further course of the disease the formerly normal morning erections upon awakening become more unusual, and finally cease altogether. Thus the despairing picture total impotency is complete.

The atonic prostate felt per anum is soft and flat. The margins, where no chronic prostatitis has been present, are scarcely distinguishable; upon pressure of the finger, one or two drops or even more are emptied out, and in these spermatozoa, along with a jelly like substance from the seminal vesicles, are to be found. After the examination, the urine will also contain the secretion. The patients state that during examination that they often feel an uncomfortable emptiness and weakness in this locality. Many have a sensation as if there were a ball in the rectum.

The cause of this disease is referable to long continued onanism in childhood or early youth and to excessive sexual congress at an early age. In addition exciting causes may be the following: Prostatitis in youth, dependent upon gonorrhoea; in later years irregular sex life, prolonged abstinence, interrupted by periods of excessive coitus, and among the married, coitus interruptus or coitus condomatus, practices in which orgasm cannot reach its normal height.

²³ Other organic causes of impotence are found in deformities of the penis, in the atrophy, tumors and indurations

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of the testicles, and in elephantiasis of the genital organs.

Symptomatic impotence of copulation is met with in certain diseases, such as diabetes, tabes dorsalis, nephritis, or obesity. At certain variable states of senility impotence is usually present.

Paralytic impotence is the last form of impotence of copulation. This type is mostly met with in grave forms of neurasthenia where the nervous elements of the entire organism are affected. The exhaustion of the spinal genital centers are especially pronounced. The genitals are withered, flaccid, the penis is in a state of atrophy, the skin of penis and scrotum is cold, shriveled, and anesthetic. The testicles are atrophied and in a state of shrinkage. The pathognomonic symptom of paralytic impotence is the entire absence of the usual morning erections.

True paralytic impotence is incurable. This incurability gave impotence in general its bad reputation which it does not deserve.

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TREATMENT--UROLOGIC

²⁸
As was stated in the opening paragraphs, there are as many degrees of sexuality as there are human beings. It is therefore essential to fit the patient into his proper category so that we shall not be led into committing the common error of attempting to restore something that never was. The most we should seek to do is to restore potency as nearly as possible to the natural sex coefficient of the individual, whatever it may be. For the determination of this coefficient we must mobilize our knowledge of the subject under the most painstaking investigation of the sexual life of the individual from his earliest days.

When there is considerable pathology in and about the veru, local applications of 10 per cent silver nitrate solution through the cystourethroscope once weekly, is decidedly effective when combined with indicated constitutional measures. These applications can be made almost painless by the previous injections of 20-30 cc. of a 2-3 per cent solution of novocain or similar local anesthetic, retained in the urethra for 15-20 minutes. With the aid of these applications, the veru and posterior urethra are decongested and eventually restored to an apparently normal appearance. Decongestion is made evident in two ways: First, by the gradually diminishing show of blood in the urine which follows the silver application in deeply congested cases; second, by the more normal appearance of the parts on urethroscopic inspection. The bleeding is the result either of the cauterization itself or of the mere contact

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of the instrument with the hypercongested tissues and ceases spontaneously within an hour or two. Polypoid and cystic bodies are best removed by fulguration.

The process is a slow one, but can be hastened and the patient made more comfortable by the daily injection of a weak solution of a mild, non irritant silver solution such as 5 percent argyrol with retention for 10 to 15 minutes with the patient in the supine position. This should be given in the interval between the weekly urethroscopic examinations.

In cases of marked seminal vesiculitis such measures do not reach the interior of the vesicles because of their inaccessible position in the pelvis. Catherization of the ejaculatory ducts is sometimes useful, but it is generally time consuming, painful and uncertain in its results. The same is true in a general way of diathermy. Therefore, for vesiculitis Belfield's vasotomy is by far the best. Thru this procedure, not only the vesicles themselves but the vasa and the ejaculatory ducts are flushed with the solution employed and in a very large measure, possibly altogether emptied of their pathogenic contents. If nothing else is accomplished in these cases than the removal of the occlusion in the ejaculatory ducts, the operation is extremely beneficial because of the improved drainage thus afforded the vesicles; with this comes a decided improvement in sexual potency.

Prostatic massage is of value when done in moderation.

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The "massage habit" should be advised against. Pneumovibration of the prostate is useful, particularly because there is less pressure trauma to the prostate gland than in digital massage.

If there is evidence of endocrine dysfunction as the predominant factor, this must be corrected in so far as possible. The reduction of excessive obesity, a common condition in these cases is a primary indication.

⁸In addition to reducing of the congestion and inflammation, the tired and exhausted sexual centers should be given a chance to recuperate. Not only abstaining from coitus, but also from "spooning," kissing, or anything that might excite these centers. At all events coitus must not be indulged in.

¹⁸In treatment of cases on the basis of atony of the prostate gland diathermy may be of value. The procedure consists in the introduction of a prostatic electrode into the rectum. The faradic current is used. [†]Echtman advises diathermization of the testicles in certain cases. The active mesh electrode is placed on the scrotum and the large indifferent electrode is placed under the buttocks of the patient who is lying on his back.

²¹Rudolph reports good results in the treatment of himself with the drug "Tetrophan". This drug is synthesized in Germany, the formula of which is withheld. In conjunction with this, iodex was massaged into the prostate. Other successful cases were cited, but were from a German clinic. According to Rudolph the German product works successfully,

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but the English product is, for some reason, not as good.

¹⁷
Plummer reports five cases successfully treated with water soluble orchitic extract used hypodermically. According to him, not only was the sexual inadequacy alleviated, but also the patients all felt better generally. This is a product of the Pickett-Thompson Research Laboratory.

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In cases of testicular atrophy homotransplants of the testicle have been tried with varying degrees of success. The procedure is known as transplantation by morcellation. The rectus muscle is split and used as a bed for the transplant. The chief difficulty is caused by the frequent absorption of the transplant.

¹²
Lowsley, in his preliminary report on the causation and treatment of impotence, describes a relatively simple and successful surgical procedure in the treatment of impotence in man.

The patient is placed in an exaggerated lithotomy position (with the legs in stumps). A number 26 French sound is passed into the urethra. An incision is made over the bulging part of the perineum, extending from the mid-line from a point 10 cms. from the anal margin down towards that structure for about 5 cms. A branch is made laterally on each side to a point just above the attachment of the crus penis, the complete incision resembling an inverted Y. The incision is deepened through fat and areolar tissue until the corpus spongiosum, surrounded by the bulbocavernosus, and the crus penis (corpus cavernosum) on each side, crossed by the ischiocavernosus, are exposed.

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Chromic ribbon gut, studded with an atraumatic needle, is inserted into the lateral edge of the muscularis bulbo-cavernosus, pulled across the belly of the muscle and passed through the other side, with just sufficient strain to plicate the muscle and produce the right amount of pressure to reinforce any contraction necessary to aid in producing an erection. Two other similar stitches may be necessary to tighten the whole muscle. The same procedure is followed with regard to the ischio-cavernosus muscle on each side, care being taken not to injure or unduly compress the fairly numerous nerves and blood vessels in this area. The wound is closed without drainage.

Before any such procedure as the above was tried on human subjects, it was first successfully carried out on dogs. These experiments indicated that tightening of the ischio-cavernosus muscle on each side and the bulbocavernosus muscle, in dogs, produces erections which are under control of the dogs mind. Fear, strange surroundings and other psychologic factors cause disappearance of the erection, while the return of the dog to his canine companions restores him.

The removal of these three muscles results in elimination of the power of having erections, in dogs, even under the strong influence of a female dog in heat, proving the contention of those physiologists who claim that these muscles play important roles in producing penile erections.

No harm has resulted in the penis and no adverse change in the general health of animals whose muscles have been tightened.

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The presence of a female dog in heat stimulates these dogs unusually. They are also stimulated by being patted a few times on the back.

In man, plication of the bulbo-cavernosus and ischio-cavernosus muscles with ribbon gut has been followed by ability to have erections and satisfactory intercourse, even in cases in which erections had been impossible for a period of years. The operation has been performed on fourteen men whose ages range from 23 to 66. The results were perfect in nine cases, all of whom had had no erections or entirely unsatisfactory ones for two years or more.

The operation must be skillfully performed, with just the right amount of shortening of the muscles, in order to accomplish the desired result. If the muscles are too tight, a constant painful erection will result; if not tight enough, satisfactory erections will not be produced. The success of the operation apparently depends upon the use of ribbon gut, which does not tear thru the delicate muscles, as does ordinary twisted catgut.

The permanency of the results cannot be proven at present.

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No matter what the treatment, the course of cure proceeds in a contrary direction from that of the development of the disease.

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CONCLUSION

1. Impotence in the male is more prevalent in the male than is usually supposed.
2. The incidence of impotence is becoming greater.
3. Impotence is a condition met with in the higher class of people as a rule.
4. Its origin is either psychic, organic or a combination of the two.
5. Most cases of impotence are psychic in origin.
6. Treatment of impotence therefore, is most often a psychiatric problem.
7. Patients showing evidence of both organic and psychic trauma should be handled jointly by the urologist and psychiatrist.
8. Cases responding well to psychiatric treatment are definitely psychic in origin; patients who respond well to urologic treatment are not necessarily suffering from impotence on a definite organic basis, as the factor of suggestion enters in.
9. The prognosis depends on the etiology and the length of time the disease has been present.

BIBLIOGRAPHY

1. Adjustor; another mechanical fraud, J. A. M. A. 94: 1619-1620, May 12, '30
2. Browdy, M. W., survey, impotency and sterility in male, Practitioner 113:19-29, July '24
3. Cassity, J. H., functional psychoses as evolution of psychic impotency, J. Nerv. and Ment. Dis. 66:105-130, Aug. '27
4. Echtman, J., diathermy; new method, Urol. and Cutan. Rev. 34:727-728, Nov. '30
5. Hirsch, E. W., sexual impotence of organic origin, Clin. Med. and Surg. 37:350-355, May '30
6. Hohman, L. B. and Scott, W. W., combined psychiatric and urologic study, J. Urol. 29:59-76, Jan '33
7. Huhner, M., diagnosis and treatment, Amer. Med. 38:144-152, April '32
8. Huhner, M., disorders of sexual function, masturbation, withdrawal, impotence, etc., in relation to conditions in posterior urethra, Med. Rec. 95:596-599, April 12 '19
9. Hyams, Kramer and McCarthy, Histopathologic study of the seminal vesicles and prostate, J. A. M. A. 98:691-697
10. Karpman, B., impotence in the male; review of book by Wilhelm Stekel, Arch. Neurol. and Psychiat. 21:924-940, April '29
11. Lespinasse, V. D., treatment by transplantation of testicle, Surg. Clinics, Chicago 2:281-282, April '18
12. Lowsley, O. S., impotence in man, South. Med. J. 28: 1091-1097, Dec '35
13. Lubash, L., cyst of prostatic utricle; causative factor in producing impotency, Am. J. Surg. 7:123-125, July '29'
14. Lydston, G. F., Impotence and Sterility, The River-view Press, Chicago, 1914
15. Maher, J. J. E., clinical notes on impotence in male; cause and cure, Urol. and Cutan. Rev. 34:728-730, Nov '30
16. Mosely, L. B., relation of verumontanitis, New Orleans M. and S. J. 84:523-525, Jan '32
17. Osnato, M., psychology and psychotherapy, Urol and Cutan. Rev. 33:530-532, Aug'29

BIBLIOGRAPHY

- 18. Poroz, M., treatment of impotence with ejaculatio praecox and atony of prostate gland, Urol. and Cutan. Rev. 36:307-308, May '32
- 19. Plummer, E. Curnow, active orchitic extract, Practitioner 119:388-391, Dec '27
- 20. Rich, C. O., impotence as seen by the urologist, Illinois M. J. 59:357-359, May '31
- 21. Rudolph, C., treatment of sexual impotence and prostatic disorders by tetrophan; some interesting officially recorded case reports, West. M. Times 46:329-335, June '27
- 22. Stokes, W. R., inadequate sexual function in male, M. Ann. District of Columbia, 2:50-54, March '33
- 23. Talmev, B. S., impotence in the male, New York M. J. 116:499-505, Nov. 1, '22
- 24. Talmev, B. S., Impotence in the male, and sterility in marriage, New York M. J. 105:296-299, Feb. 17, '17
- 25. Thom, B. P., signifigance and treatment, New York M. J. 105:601-602, Mar. 31, '17
- 26. Wallace, W. J., impotency in young men, etiology, pathology and treatment, J. Urol. 13:193-203, Feb. '25
- 27. Welfeld, J., psychic impotence in male, Illinois M. J. 58:134-140, Aug. '30
- 28. Wolbarst, A. L., urologic aspects, J. Urol. 29:77-94, Jan. '33
- 29. Young, J. and others, discussion of impotence, Brit. M. J. 1:1117-1118, June 27, '31