# Aspects of Sexual Medicine

# Some of the Commoner Sexual Disorders

## I. Problems Mainly Affecting the Male

R. W. TAYLOR

*British Medical Journal*, 1975, 2, 739-741

### Clinical Presentation

It is convenient to consider sexual problems according to their initial clinical presentation. They fall naturally into problems affecting primarily the male partner and those affecting primarily the female partner. When it comes to dealing with patients, however, it is a fundamental principle that both partners may be concerned in the aetiology of the disorder and both must be involved in treatment. It is a truism that there is no such thing as an uninvolved partner in any marital problem. Diagnosis and treatment rest on prolonged interviews with both partners. Often they are seen separately at first, but eventually the interviews are between couple and therapist.

The incidence of sexual disorders in any community is difficult to compute because many remain undisclosed. There is a further difficulty because couples who present for treatment largely select themselves. In some reported series the couples who elect to seek help are the most educated and articulate members of the community. In others, where the cost of therapy is considerable, only the wealthier and thus almost by definition the middle-aged members of society are included. The attitude of society to sexual disorders is also important. Where sexual performance is an everyday topic, couples who think their achievement falls short of the average may seek advice. In other societies where sexual topics are rarely discussed only the most serious problems come to light. Finally the level of expectation is important. For example, in a previous generation in our own society women's expectation of enjoyment of intercourse was very restricted. Personal interrogation of women of middle and working class now aged 50-70 years suggests that few experienced regular orgasm, many never achieved it at all, and none thought it a topic for complaint to a doctor. Today it is rather more likely that a doctor will see at an early stage in a marriage the woman who responds poorly to sexual stimulus and thus achieves little satisfaction from intercourse.

Because of these difficulties it is impossible to compare the experience of one school of therapy with another. The patients treated at Masters and Johnson's clinic in St. Louis, U.S.A., for example, differ in culture, education, and financial standing from those referred to my clinic by marriage guidance councillors and family practitioners in the Lambeth district of London. No attempt has been made therefore in the discussion that follows to indicate the frequency of the different disorders. Comments on the technique of management are based largely on personal experience, though the comments of other therapists are interwoven where it appears appropriate.

St. Thomas's Hospital, London S.E.1
R. W. TAYLOR, M.D., M.R.C.O.G., Professor of Obstetrics and Gynaecology

Sexual problems which cause the male partner to seek advice include premature ejaculation, ejaculatory failure, and impotence, which may be either primary or secondary. Occasionally the level of sexual desire in one partner does not match that of the other, but to a surprising extent married couples find themselves well matched. When the woman with a basic dislike of intercourse marries at all, she usually marries someone who is likely to make few demands on her, and the man with a weak sex drive will rarely find himself matched, at least in western society, to a woman with an insatiable sexual appetite. Problems of waning sexual drive are not commonly seen either, because in the majority of marriages this natural evolution occurs in both partners at about the same time.[1] It is only when there are widely disparate ages, or the sexual performance of one partner is affected by disease or perhaps by such therapeutic ventures as hypotensive drug therapy, that difficulties are at all common. In these circumstances a reasoned explanation of the difficulties usually ensures marital harmony.

### Premature Ejaculation

An adequate definition of premature ejaculation is surprisingly difficult to arrive at from any study of the literature on the subject.[2-5] In some studies the time the penis can be contained within the vagina before ejaculation is used to arrive at a definition. However, the length of time the penis must be contained within the vagina to secure orgasm in the woman varies according to the stage of excitement reached before penetration. As premature ejaculation is to be considered only in relation to whether or not the woman can be helped to achieve orgasm, Masters and Johnson's practical definition is the most satisfactory.[6] In their studies a man was labelled a premature ejaculator if he was unable to control ejaculation sufficiently well to ensure orgasm in his partner on at least 50% of the occasions when intercourse was attempted. Premature ejaculation by any definition is not nearly such a common complaint in my own experience as in that of many American therapists. Clearly the number of couples seeking advice will largely be determined by the average expectation of sexual satisfaction among women in a society. On that score it is likely to appear as an increasing problem in British practice.

The most consistent finding in the sexual histories of men with premature ejaculation is a conditioning to a pattern of rapid passage through all the stages of the sexual response. Common among situations in which ejaculation has to be completed rapidly include early experience with prostitutes and premarital intercourse in anxious circumstances. Intercourse in the front parlour while the rest of the family are watching television in the back room is a good example of such circumstances, which I have noted twice in recent years. Vaginismus in the wife, leading to difficulty in penetration but giving sufficient stimulation to the glans penis to initiate ejaculation can also set an

undesirable pattern for future reaction. Indeed any distaste on the part of the woman, leading to the desire to "get it all over quickly" can condition the husband in this way.

As with most sexual problems the most important therapeutic factor is the will of both partners to correct the situation. Frequently it has existed for several years before advice is sought. The sexual history must include an analysis of how each partner developed their attitude to sex, marriage, and pregnancies, as well as their first experiences together. This will often show the reason for the development of the abnormal pattern and will in itself be therapeutic, in that during conversations a more helpful attitude to the sexual relationship can be suggested to both partners.

## Discussion with Therapist

Practical and specific advice includes suggestions for positioning and manipulation of the glans penis by the woman. Often the female-superior position after an appropriate period of love play will itself suffice to delay ejaculation long enough for the woman to achieve orgasm. If not, firm squeezing of the glans between the woman's finger and thumb just before the rhythmic contractions of the urethral musculature begin, will inhibit ejaculation and allow the love play to continue. By repeating this manoeuvre once or twice sufficient stimulus can usually be achieved to bring the woman nearer to orgasm before final penetration and emission occur. Obviously the woman must have some understanding of the degree of sexual tension achieved by her husband. Only he can communicate this to her, but by discussing this problem with a therapist the couple can usually be brought to an understanding of what is happening.

Drug therapy can be helpful in dealing with premature ejaculation but should never be used to the exclusion of the type of approach outlined above. It is important that the couple correct the attitude which has resulted in the abnormality rather than become dependent on the support of drugs. Reserpine in low dosage, such as 0·1 mg per day, will effectively delay ejaculatory response without having any serious effect on the blood pressure. Whatever the mode of therapy, the prognosis for the effective treatment of premature ejaculation is good. The most important feature may be the recognition of the couple themselves that they have a problem.

## Ejaculatory Failure

Here we are dealing with the reverse of premature ejaculation. There is an inability to ejaculate though there is no difficulty in obtaining an erection and maintaining it long enough to achieve satisfactory penetration of the vagina. The failure may be total or it may be that ejaculation can be achieved by masturbation or with a different partner. After repeated failure to ejaculate, it is not unusual for secondary impotence to develop. As this makes the likelihood of successful therapy more remote, the earlier adequate treatment is made available the better.

As with premature ejaculation the most important element in treatment is the analysis of the sexual histories of the couple concerned. Frequently—in about half of all cases in my experience—instruction of the man on sexual matters during childhood was strongly prohibitive. Sometimes there is apparently a religious basis for the negative attitude. However, this problem is neither common to people of strong religious views nor confined to them. One particularly intractable problem I have had to deal with concerned the son of an unmarried mother of no religious persuasion. Resenting her own situation she had made such a deep impression on her son that he regarded the idea of intravaginal emission with distress. Occasionally one finds dislike or even total rejection of a partner which appears to account for failure to ejaculate intravaginally. In these few cases the concern of the couple may be their inability to achieve a pregnancy, desired for family or financial reasons. Therapy has little to offer such couples. Occasionally, too, one finds a deep-seated fear of pregnancy on the part of the husband concerned. This fear in itself often reaches pathological levels and requires careful analysis if its cause is to be found. Relief from the fear either by explaining it away or by use of a trusted family planning technique is effective therapy in most of these cases.

### TRAUMATIC EPISODE

A secondary ejaculatory failure may occur as a consequence of one specific, traumatic episode. In one case, for example, the husband was trusted with the family planning technique when both partners had decided that pregnancy was absolutely out of the question for financial and social reasons. The distress and subsequent recrimination of his wife when a condom burst as he was ejaculating caused such tension that intravaginal emission became impossible. In these cases too the uncovering of the cause of the problem and appropriate reassuring steps usually result in a cure.

Specific treatment of primary ejaculatory failure is directed to stimulation of the penis. Rather than squeezing the glans the female partner must manipulate the penis in whatever fashion the male finds exciting or demanding. As this process must initially be taken to the length of securing ejaculation manually it may occupy a considerable time. Gentleness is important, or the penis, particularly the glans, may become sore, and this in itself then becomes a factor tending to produce a therapeutic failure. Moisturizing creams are helpful in preventing trauma, and some couples have found particular scents helpful. Once successful ejaculation has been brought about manually it is a comparatively short step to arrest the stimulating process just in time for the woman to place the penis into her vagina and encourage ejaculation there.

The need to involve both partners in the treatment of ejaculatory failure is obvious. In some centres "substitute" wives have been made available to men with such problems. The idea behind this approach is to make use of the woman's own satisfactory sexual experience when his own wife is unable or unwilling to participate, or when there is no immediate female partner. I have no experience of the value of such "surrogate" partners. Clearly the social and ethical problems they present are as formidable as the medical difficulties.

## Impotence

This is perhaps the commonest of the male problems seen in Britain. By impotence we mean that erection either cannot be achieved or is not maintained long enough to permit penetration of the vagina. It can be either primary, when it usually has a psychological cause, or secondary, when it may have either a physical or a mental basis.

### PRIMARY IMPOTENCE

It is doubtful what part testicular hormonal function plays in determining primary impotence. There are rare instances of congenital testicular dysfunction such as Klinefelter's syndrome, in which the hormonal balance is clearly at fault, but these are rare. Spermatogenesis may be abnormal, as in the case of maldescended testicles, but steroid production is usually adequate, and normal intercourse and ejaculation takes place. Certainly from a therapeutic point of view hormone therapy is almost always without value. In most cases the cause of primary impotence may be found in the family background or in traumatic early experiences. A derogatory or hostile attitude to sex and reproduction is almost invariably harmful to the developing child. Sometimes there is a quasi-religious element

in this rejection of sex, but it is unwise to overstate this. Indeed practical experience leads one to the belief that individuals with built-in problems seek religious sanction for their prejudices rather than that a religious attitude discourages a healthy sexual outlook.

Traumatic early experiences can certainly lead to difficulties, particularly in those predisposed by a low sexual drive. A clear example of this was the young man whose first sexual experience was with a prostitute, an experience, it was arranged, to be shared with three friends for reasons of economy. He was the lucky, or unlucky, companion who was deputed to be first. His inexperience, combined with the encouraging comments of his friends through the closed door, ensured his lack of success and his subsequent impotence.

Latent or overt homosexuals may well be found suffering from primary impotence with a female partner. Here too, of course, family background may be significant.

As with the other problems already considered, analysis of the problem and re-education to a more healthy regard for sex are most important. Specific stimulation by the female partner may be of value, but it is unwise to expect too much of this approach. Often "like marries like," and a couple may be content to live without intercourse by mutual consent until perhaps their friends or relatives question them about lack of a family. In such circumstances complete success for any form of therapy is rare. Even if successful intercourse and pregnancy are achieved, such couples rarely feel the need or indeed obtain any great satisfaction from their physical relationship.

### SECONDARY IMPOTENCE

This is a commoner problem and usually more amenable to management. Physical causes may be entirely responsible or perhaps make a major though indirect contribution to the problem. Testicular loss, general endocrine disorders, perineal prostatectomy, and neurological diseases such as multiple sclerosis may explain the situation completely. Angina, severe dyspnoea, hypotensive drugs, and painful local lesions such as phimosis may be important factors without interfering directly with the mechanism of erection. If a physical cause is found it may not or more likely will not be amenable to treatment. The problem then becomes one of marriage counselling.

More commonly secondary impotence is a consequence of a complex of physical, social, and psychological factors. It is most frequently seen in those of middle age, under stress, socially and financially successful. Cultural elements are important because the greater the demand for male excellence in performance the higher is the rate of secondary impotence. Overwork, physical and mental strain, and alcoholic episodes are usually found when the analysis of the problem takes one back to its origin. Frequently there has been marital disharmony for some time, perhaps connected with business problems, perhaps going back further. Certainly it is common to find that premature ejaculation and failure of the wife to achieve orgasm over many years has been a feature of the marriage. Probably because of the underlying disharmony the results of failure to achieve erection are magnified. Anxiety to avoid further failure makes it only more likely, and if the help of alcohol is sought further failure is virtually assured. The more frequent the failure the more critical the partner, and the worse the situation becomes. Compounding the difficulty is often a wife's fear of her husband's infidelity, and in some circumstances his own seeking of reassurance about his sexual abilities outside marriage.

In spite of the daunting nature of these problems, secondary impotence of this type can almost always be dealt with. Analysis of the problem with the couple, resolution of their underlying fears, shedding of business cares at least for a time, and above all the discouragement of the man from a constant analysis of his performance offer the real prospect of restored potency and marital happiness.

This paper, and the clinical examples cited, form part of an analysis of 200 personal cases of sexual dysfunction referred to me during the past eight years and previously unpublished though publicly discussed.

### References


1 Amulree, Lord, *Practitioner*, 1954, **172**, 431.
2 Ahmed, S. H., *British Journal of Psychiatry*, 1968, **114**, 1197.
3 Bergher, E., *International Journal of Sexology*, 1950, **4**, 14.
4 Dengrove, E., Marcus, D. M., and Cook, E. N., *Journal of the American Medical Association*, 1963, **183**, 389.
5 Taubel, D. E., *American Journal of Psychiatry*, 1962, **119**, 87.
6 Masters, W. H., and Johnson, V. E., *Human Sexual Inadequacy*. Boston, Little, Brown, 1970.


### Further Reading


O'Malley, P. P., *Journal of the Irish Medical Association*, 1968, **61**, 85.
Ovesey, L., *American Journal of Psychotherapy*, 1968, **22**, 185.
Roen, P. R., *New York Medical Journal*, 1965, **65**, 2576.
Semens, J. H., *Zeitschrift für Urologie*, 1959, **52**, 381.
Simpson, S. L., *British Medical Journal*, 1950, **1**, 692.


# *Outside Medicine*

# Thomas Gann in the Maya Ruins


J. E. S. THOMPSON



*British Medical Journal*, 1975, **2**, 741-743


Thomas William Francis Gann (1867-1938) was the son of William Gann, of Whitstable, and Rose Gann, née Garvey, of Murrisk Abbey, Mayo, Eire. Though born at Murrisk Abbey he grew up in Whitstable. His parents were prominent in the social life of that then small town, in which young Somerset Maugham, seven years Gann's junior, also moved.

Maugham named his strumpet heroine of *Cakes and Ale* Rosie Gann, and has her a native of Whitstable, thinly disguised as Blackstable, in which the early scenes of the novel are laid. Several characters in this book have been widely recognized as portraits of persons the author disliked. Accordingly, it may well be that Maugham, whose sense of spite was acutely


**Saffron Walden, Essex**
SIR ERIC THOMPSON, LITT.D., F.B.A.