CONSTITUTIONAL FACTORS IN MALE POTENCY DISORDERS*

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SUMMARY

Fifty five patients of sexual inadequacy were studied for libiduous strength and androgyny score. Androgyny score was compared with a normal male population. The results show that premature ejaculators and patients with secondary disorders have a high sex drive. Androgyny scores did not differentiate the patients from controls as well as different subgroup of potency disorders. Biliiac diameter of patients with erectile impotence was more than the patients with premature ejaculation.

Male potency disorders have become the focus of attention in last few decades. Various investigations blamed poor results of therapy on constitutional factors (Cooper, 1968; Johnson, 1965; Kaplan, 1974; Agarwal, 1975; Nakra et al., 1977). However not many workers have studied so-called constitutional factors in relation to sexual disorders. Androgyny and Libiduous Strength are said to be constitutionally determined.

The term androgyny may be defined as the presence of androide features in women and gynaecoid features in men. For a long time physical anthropologists have used the ratio biliiac diameter/biacromial diameter as a rough measure of androgyny, on the grounds that these are the two measurements which relatively speaking, differentiate most, the two sexes. Tanner (1951) derived a discriminant androgyny score, for measuring androgyny or feminity of build in the male and masculinity of build in the female, based upon the measurements of the biacromial and biliiac diameters, which was arrived at by substitution in the formula $3 \times$ biacromial — biliiac diameter (in cm). Tanner (1951) obtained a score of 90.1 with a standard deviation of 4.73 for men, the comparable figures for women were 78.9 and 4.57. This sex difference in physique arises at puberty, and before this age the androgyny score fails to discriminate between the two sexes (Coppen, 1959). Various workers (Roboch, 1957; and Johnson, 1965) found the evidence that subjects who suffer from certain abnormalities related to sexual dysfunction showed abnormalities in their androgyny score.

It was anticipated that males with a disorder of sexual potency would have a wider scatter of androgyny scores than a normal male control group and would show a shift towards the gynaecoid end of the distribution.

Libiduous strength is also said to be innately determined. Kinsey et al. (1948) stated that sexual performance, is normally distributed along a continuum, at one extreme, some high drive, high potency subjects averaging 30 or more coital outlets per week over many years; at the opposite pole are some males with very low drives, who have apparently never engaged in any type of sexual activity to orgasm and ejaculation in their entire life. So it was decided to study the androgyny score and libiduous strength in a group of patients with diagnosis of sexual inadequacy. The aims of this study were:

(a) To study the relationship between androgyny scores of normal controls and patients with potency disorders.

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(b) To study the relationship between libido and different types of potency disorders.

MATERIAL AND METHODS

The subjects of this study were selected from the out-patient Psychiatric Clinic of G. M. & Associated Hospitals, Lucknow. All patients who presented with disorders of potency and did not have any other major psychiatric or organic illness were included in this study. Sexual inadequacy was sub-classified as under:

Impotence:
Persistent inability to obtain an erection sufficient to allow orgasm and ejaculation during heterosexual coitus (Hastings, 1963).

Premature Ejaculation:
A condition wherein orgasm and ejaculation persistently occur before or immediately after penetration of the female introitus during heterosexual coitus (Schapiro, 1943).

Retarded Ejaculation:
Persistent inability to experience orgasm or ejaculation during heterosexual coitus in spite of normal erection and sexual desire (Johnson, 1965).

Each disorder was considered primary when it was present since the first heterosexual contact and secondary when it developed after a period of successful heterosexual experience.

Only those cases considered as psychogenic were taken up for this study and cases secondary to organic pathology, severe depression, drug intake, schizophrenia as well as those having only apprehension of potency were not included in the present sample.

During the study period of eight months, (i.e. 1st September 1978 to 30th April, 1979) 55 male patients fulfilled the above criteria and constituted the sample for the present study.

In the present study sex drive has been measured in terms of mean number of sexual outlets per week over any three months of maximum performance and in terms of frequency of multiple orgasms in a 24 hours period (Nakra et al., 1977).

Following measurements were taken by the investigator using a spreading caliper. The patients were measured while standing with their shoulders relaxed.

1. Biacromial Diameter:
Maximum distance between the two acromial points (Superior and external border of the acromian process).

2. Biiliac Diameter:
Maximum distance between the external margins of two iliac crests.

As normal value of Androgyny score for Indian population is not available, this score was compared with a group of control subjects which were matched with the experimental subjects in terms of sex, age and ethnic origin.

RESULTS

Sample of the present study comprises of 55 consecutive male patients, who attended psychiatric O. P. D. for the disorder of potency as one of the chief reasons for consultation during the period of study. Most of these patients were referred from other departments of the hospital. Thus the sample can not be said to be the true representative of the potency disorders in general. The patients were largely cooperative and no difficulty was encountered in data collection except that many patients found it difficult to give precise information on some of the questions. No case was left out as investigator completed the evaluation in one session only.
DISTRIBUTION

| No. of | Erectile Impotence | Premature Ejaculation |
|--------|--------------------|------------------------|
|        | (N=15)             | (N=40)                 |
| N      | %                  | N                      |
| Primary| 8 53.3             | 15 37.5                |
| Secondary| 7 46.7              | 25 62.5                |

In the present sample 15 patients presented with the problem of erectile impotency whereas 40 patients suffered from premature ejaculation. There was no patient of retarded ejaculation.

As 8 patients suffering from erectile impotence had this problem since first heterosexual experience, they have been included under the category of primary disorders. On the other hand, 7 patients developed erectile insufficiency after a period of successful functioning and therefore they have been classified as suffering from a secondary disorder. Similarly 15 and 25 patients in premature ejaculation group suffered from primary and secondary disorders respectively.

SEX DRIVE

| No. of Erectile Impotence | Premature Ejaculation |
|--------------------------|------------------------|
| outlet in 24 hrs.        | (N=15) (N=40) (N=23) (N=32) |
| 1                        | 2 3 4 1               |
| 2                        | 4 7 9 2               |
| 3                        | 3 11 5 9              |
| 4                        | 5 4 1 8               |
| 5                        | 1 9 3 7               |
| 6                        |                       |
| 7                        | 2 1 1                 |
| 8                        | 3 3 3 3               |
| Mean                     | 2.9 3.8 2.6 4.1       |
| s. d.                    | 1.2 1.8 1.5 1.7       |

\[X^2=12.36, \text{ d. f.}=1, p<0.001. \]

When the 2 groups were compared for number of maximum outlets in 1 week it was found that premature ejaculators had 16.3 mean outlets, while patients suffering from erectile impotency had 9.1 mean outlets in 1 week, which confirms the impression that premature ejaculators have a stronger sex drive in comparison to the patients suffering from erectile impotency. This difference in terms of sex drive was highly significant (p<0.001).

When primary and secondary groups were compared in respect to sex drive it was observed that cases with a secondary type of disorder had significantly stronger sex drive than the primary type (p<0.05).

The observations indicate that patients with erectile impotence and primary disorders have lower sex drive than that of premature ejaculators and secondary disorders.
Androgyny score was obtained for the patient group as well as for a control group of 100 males. Controls were matched for age and sex and those having any sexual problem were not included in the control group. There was no significant difference between controls and potency disorder group as well as amongst the subgroups of potency disorders. There was only slight significant difference (p<0.05) in the biiliac diameter of erectile impotence patients and premature ejaculators.

**DISCUSSION**

The sample of this study consisted of 55 patients who have been referred to Psychiatry O. P. D. Thus a preselection has taken place and the sample can not be said to be true representative of potency disorders in general.

Sex drive when compared in terms of number of outlets in 24 hours did not differentiate premature ejaculators from erectile impotence but the patients with primary and secondary disorders significantly differed from each other. It indicates that patients suffering from primary potency disorders have a low sex drive. When sex drive was measured on the basis of number of outlets in one week it was found that premature ejaculators have significantly higher sex drive than the impotence. Similarly patients with secondary disorders had a higher sex drive than those having primary disorders. Sexual drive was not compared between primary and secondary subtypes of premature ejaculation and impotents as the number was too small. Our observations substantiate the findings of Schapiro (1943), Johnson (1965) and Nakra *et al.* (1977) that premature ejaculation had stronger sex drive than the impotence. As the norms of sex drive for the healthy population are not available, we will not be able to comment on Cooper’s (1968) observations that though the premature ejaculators had a higher sex drive than impotents, yet it is less than normally functioning population.

Johnson (1965) measured androgyny
score in male potency disorders and found that androgyny score of these patients differed significantly from normal persons. Similar observations was also made in regard to Biacromial diameter. Johnson divided his group into those with and without the evidence of neurotic constitution. The androgyny score of neurotic group showed significant difference from the controls while in second group the difference barely reached significance. He also found a significant difference in androgyny score between the potency disorder of early onset type and control group while late onset group where psychological factors are more likely to play a role did not show a significant difference on this measurement. We could not find any significant difference between the normal controls and our sample as well as between different sub-types of potency disorders. There was only mildly significantly difference in Biiliac diameter between the patients of erectile impotency and premature ejaculation. Our results do not correspond with those of Johnson's. This difference can be due to the fact that patients suffering from potency disorder constitute a heterogenous group and if patients, where psychological and cultural factors are more important causative agent, are in preponderance in the sample then the effect of constitutional factors may become too small.

Concluding it can be said that patients suffering from erectile impotence and primary sexual inadequacy have low sex drive while patients suffering from premature ejaculation and secondary disorder have a stronger sex drive. Androgyny score does not seem to differentiate the patients of sexual inadequacy from normals. The major application of this study is in treatment of potency disorders where high libidinous subject should be treated differently than low libido subjects.

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