Archives of Sexual Behavior, Vol. 2, No. 2, 1972

Social and Psychiatric Aspects of Impotence and Premature Ejaculation

Lars Lidberg, M.D., M.A.[1]

A population of 201 Swedish nonpsychotic outpatients with complaints of impotence and premature ejaculation was examined. Impotence was defined as the inability to achieve erection and premature ejaculation as anteportal ejaculation, ejaculation immediately after insertion, or ejaculation which the patient desperately attempts to delay, invariably without success. This study concerns the family background of the patients, especially parental age, the patients' social background, occupation, socioeconomic status, and the occurrence of psychological disturbances. More than one-third of the patients who had been raised in a complete family were only sons, in contrast to the estimated corresponding frequency of only sons in the Swedish population of 6%. Parental age of the patients was higher than the estimated average for Swedes of the same age as the patients. There was no difference between the number of patients who had been born out of wedlock and the frequency in the ordinary population. The occupational status of the patients more often included technical and economic professions compared to the average distribution of professions in Sweden; there was a marked preponderance of engineers. No common psychiatric signs or symptoms characterized the patients in the two groups.

INTRODUCTION

Systematic reviews of series of patients with symptoms of impotence and premature ejaculation are uncommon, despite the prevalence of these problems (Blend, 1967). Of the two symptoms, premature ejaculation appears to have attracted the greater interest. Thus Schapiro (1943) reported on 1130 patients with these symptoms, all treated by him over a period of 21 years. Levie (1953) reported on a series of 1200 patients suffering from premature ejaculation, and Abraham (1927) reported analyses of similar patients.

[1] Laboratory for Clinical Stress Research, FACK 10460, Karolinska Sjukhusef, Stockholm, Sweden.

The symptoms presented to the general practitioner are often diffuse and unspecific, e.g., fatigue and weakness. Patients often request a "general check-up" or ask for vitamins or a tonic. Despite enduring or increasing distress, the first contact with a doctor is often drastically broken off after one single consultation. Also, when patients openly discuss their symptoms from the beginning, they often receive only breif, clumsy, superficial therapy, even from doctors trained in psychiatry. This reflection of medical uncertainty and ignorance often leads to an unfortunate termination of consultations.

A number of studies (e.g., Johnson, 1969) show that prognosis deteriorates with the duration of symptoms. The low level of knowledge regarding these symptoms is one of the reasons why the Swedish Association for Sexual Education (Riksförbundet för sexuell upplysning–RFSU) provides a psychiatric consultation service at clinics in Stockholm and Göteborg, Sweden. The goals and principles of this activity, which include increasing the fund of knowledge about psychosexual problems, have been reported by Dahlin (1969). The present survey is a social-psychiatric analysis of patients who consulted the author at the RFSU Clinic in Stockholm. It is one step in a description and follow-up of this psychiatric advisory service. The occurrence of somatic disorders in these patients has been reported previously (Lidberg, 1970).

DEFINITIONS

Impotence is here taken to mean inability to achieve erection *prior to* or *during* coitus without ejaculation. Premature ejaculation refers to anteportal ejaculation, ejaculation immediately after insertion, or ejaculation which the patient attempts to delay, invariably without success despite such a desire. Ejaculation occurring at a time undesired by and against the will of the patient and conflicts with the partner over this are criteria necessary in establishing the diagnosis of premature ejaculation. Thus a distinction is made between the latter and impotence, which is not always the case in other reviews of these problems (Noy *et al.*, 1966; Blend, 1967). A distinction between the symptoms was also considered justified, as patients consulting the RFSU Clinic with symptoms of premature ejaculation seldom had, as also found by Masters and Johnson (1966), difficulty in attaining erection.

Another reason for distinguishing between these disorders is the extreme variety of opinions by different authors regarding premature ejaculation, that this is associated with emotional immaturity (Abraham, 1927), with neurotic personality (Simpson, 1950), or with a kind of psychosomatic disorder (Schapiro, 1943), or that it represents a biologically "superior" reactivity (Kinsey *et al.*, 1948). Kinsey *et al.* justified the latter view by the fact that a biological organism which displays rapid reactions can only be regarded as being biologically superior to one with slow reactions. They consequently attributed distress

arising from this condition entirely to the culturally conditioned hypoactivity of the female.

MATERIALS AND METHODS

Subjects

Two hundred and eighty-three patients who consulted the author at the RFSU Clinic in Stockholm from October 1964 to October 1968 made up the original population. The majority came on their own initiative. Only seven had been referred by a doctor. However, a few had been advised by general practitioners or psychiatrists to consult the RFSU Clinic. Patients visiting the Clinic were requested to fill out and return a questionnaire.

Because long queues developed, a selection based on information in the questionnaires was periodically made by the Clinic's social assistant. Patients who had a long distance to travel were requested to consult a local doctor, and patients who described essentially urological or psychiatric symptoms were advised to consult urological or psychiatric departments. However, the series is largely unselected. Most patients were residents of Greater Stockholm. A few had traveled a long way to visit the Clinic. These patients had often consulted a number of doctors previously without getting any "help," which is why they sought a "specialist." Shame, shyness, or personal acquaintance had prevented a few from contacting local doctors.

Of the patients, 201 (71%) reported distinct impotence and premature ejaculation. The sex distribution and the manifest symptoms in other patients consulting the author are given in Table I. Most of the patients attending the Clinic were males. Sexual perversions were uncommon.

Patients recording distress from both impotence and premature ejaculation were placed in the impotence group. Using this division, 111 patients displayed symptoms of impotence and 90 of premature ejaculation.

Method

Questions about background were asked routinely in taking the history. Strict, formalized questioning did not take place. The background data analyzed here were obtained in a uniform manner, so that a random distribution may be assumed for any incorrect information.

Selection

The following survey includes only those patients seeking assistance for impotence and premature ejaculation. There are not enough females or patients

Table I. Symptoms Other than Premature Ejaculation and Impotence[a]

	Women			Men				
Age group	Marriage problems	Anor-gasmia	Frigi-dity	Fear of small penis	Fear to be homosexual	Marriage problems	Masturbation anxiety	Total number of patients in age groups
>50		1			2	1	2	53
50-41	3	4	1			1	1	49
40-36	3	2	2			3		44
35-30	1		7	1	1	2		47
29-25		10		1	1	1[b]	2	44
24-20			10	2	2	1	1	41
	7	17	20	4	6	9	6	278

[a] Additional symptoms: Women—genital itch, 1; fear of masturbation, 1; vaginismus, 1; dyspareunia (pain at coition), 1; total number of patients, 283. Men—induratio penis plastica, 1; failure at ejaculation, 1.
[b] The wife was impenetrable.

with symptoms other than these to permit a statistical analysis of social background factors for these groups.

RESULTS

Primary Group Conditions: Birth and Siblings (Table II)

Approximately 4% of the patients grew up in broken homes and 4% were born out of wedlock. Twenty percent of all patients grew up as only sons and 15% as only children; 21.5% of the patients who had been raised in complete homes up to the age of 15 were only children and 17% were only sons. Thus more than *one-third* of all patients raised in a complete family and seeking aid for these two conditions were only sons.

Age of Parents

The ages of the parents when the patient was born are shown in Table III.

Table II. Primary Group Conditions in Patients with Premature Ejaculation and Impotence

	Premature ejaculation (*N*)	Impotence (*N*)	Percent of all patients	*N* (Total)
Born out of wedlock	7	0	3.5	7
Broken home before the age of 15	4	4	4	8
Only son	21 (26%)[a]	9(12%)[a]	15	30
Only child	8 (10%)[a]	14(19%)[a]	11	22

[a] Calculated in percent of each group of symptoms.

Table III. Mean Age of Parents of Patients with Premature Ejaculation and Impotence at the Time of Birth of the Patients

	Father (years)		Mother (years)		
	Mean	SD	Mean	SD	*N*
Premature ejaculation	35.6	7.6	32.7	6.4	28
Impotence	36.5	7.9	33.3	7.3	35

Included are only the parents of nonpsychotic patients who did not suffer from somatic disease which could be assumed to have pathogenic significance and who had lived in complete homes up to the age of 15 (Lidberg, 1970). Since the age distribution is skewed, the median should represent a reliable value. On the average, parents of patients with impotence tended to be somewhat older. The large difference between the average and median age of the mothers of these patients is due to the fact that some mothers were very young. These young mothers were all married to much older men.

Social Background: Marital Status

About 70% of the patients were married. Twenty-five percent had had long contact with their partners. Thus the patient group did not consist of so-called emancipated libertines (Dahlin, 1969). A similar patient make-up has been reported from the RFSU Clinic in Goteborg, Sweden (Carlsson and Westrin, 1969). The patients without a liaison of long duration were younger men with premature ejaculation with only temporary sexual partners. Patients with premature ejaculation often discovered their complaint only after starting to "go steady" or only after marriage; they had not "noticed anything" previously. A surprising number of patients had lived with their parents until they were 25 to 30 years old.

Age Distribution

The patients' age distribution is shown in Table IV. The oldest patients complained more often of impotence. In age groups under 50, both symptoms occurred to about the same extent. However, impotence was the dominant symptom in all age groups, except the youngest.

Table IV. Premature Ejaculation and Impotence Age Levels

Age	Impotence	Premature ejaculation	Percent with impotence	Total number of patients	Ratio premature ejaculation/impotence
>50	35	3	92	38	11.7
50-41	24	15	62	39	1.6
40-36	15	19	44	34	0.8
35-30	12	23	34	35	0.5
29-25	13	17	43	30	0.8
24-20	12	13	48	25	0.9
Total	111	90		201	

Occupation

Table V groups patients according to occupation. There was a preponderance of technical and economic occupations. Salesmen were also common. The majority of patients were highly educated. Higher education was more common among younger patients.

Socioeconomic Grouping

Table VI distributes patients by socioeconomic groups according to the Swedish census. This is based on education, income, and degree of professional responsibility. Social group II, which dominated, is made up of high-school educated people and people with moderate incomes.

Emotional Disturbances

Emotional disturbances, over and above psychosexual difficulties, were most often anxiety neuroses. Eleven percent of the patients, including most of

Table V. Professions of the Patients

Engineers (6 high-school educated)	35	Railway men	5
Mechanics	24	Policemen	4
Salesmen	12	Service station and newstand managers	4 (1)
Accountants (4 high school educated)	11	Data operators	3
Employees	11	Electricians	3
Drivers	10	Store laborers	3
Clerks	9	Artists	3
Foremen (supervisors)	7	Shipping agents	2
Carpenters	6	Tramway men	2
Manufacturers and enterprisers	6	Typographers	2
Students (philosophy, 3; technical, 2; economics, 1)	6	Attendants	2
Unskilled laborers	5	Miscellaneous	28

Table VI. Social Group of Patients with Premature Ejaculation and Impotence

Social group[a]	Number	Percent
I	28	13.5
II	91	45
III	73	38
Unknown	9	
Total	201	

[a] Group I: (a) high-school educated people, (b) officers, (c) persons with high income or great property. Group II: (a) owners of medium-sized farms or enterprises, (b) upper middle-class occupations, (c) lower middle-class occupations. Group III: (a) small holders, (b) semi-skilled manual workers, (c) unskilled manual workers, (d) no permanent occupation. (From Korpi, 1964.)

those with premature ejaculation, complained of this disorder. In general, the incidence of emotional disturbances was low, including the misuse of alcohol and barbiturates.

Clinical Impressions

In most patients with impotence aggression appeared to be severely repressed. The same circumstance has been reported by Noy *et al.* (1966) in an undifferentiated series of patients suffering from impotence, premature ejaculation, and retarded ejaculation. Almost all the patients were well adjusted and enjoyed their work. All displayed outer conformity in social activities, were industrious and devoted, and often held extra jobs. Their sexual behavior was almost severely compulsive. There was often a marked discrepancy between the way in which the patient introduced and described himself, occasionally boastfully using slang, and the facts as implicitly surmised and subsequently confirmed. They were extroverted, occasionally cynical, daring, and self-assured men in their personal description, but even their psychomotor behavior was passive, evasive, and frightened.

In many cases, the clinical picture of patients with premature ejaculation was in good agreement with the two main patient groups described by Abraham

(1927), i.e., one inert and passive and one erethistic and overlively. However, the borderline between these groups is not well defined. About thirty percent of the patients with premature ejaculation were passive, devoid of energy, and, in popular terms, unmanly. They had an infantile, dependent attitude to females, saw the female as a mother figure, and expected to be treated by women as small children in search of consolation. Most of them had grown up in homes strongly dominated by the mother, and almost 40% had lived with their parents until early middle age. About 15 percent were irritable, seemingly energetic, busy, and excessivly lively men "in a constant state of rush"; they appeared habitually aggressive, restless, and impatient. These were men who had to execute all their plans at a fever pitch before some inner resistance put a stop to all activity; many of them were employed as salesmen. Occasionally, these men began by describing themselves as "oversexed," unable to find satisfaction with *one* woman, "compelled" to seek out others. However, the anamnesis for both these typological patient categories was unambiguous. Most of the time, the patients suffered from premature ejaculation from the time of sexual debut. They had expected spontaneous remission with increased sexual "experience," but this never developed.

DISCUSSION

Comparisons with official statistics show that the parents of patients in both symptom groups had a higher average age at the time of the patient's birth than the average for childbearers in Sweden. The special 1935/1936 census gives the age at marriage for the wife and the number of living children in surviving marriages (SOS, 1939). The wife's average age at marriage in all marriages with children is calculated from Table 13 in the survey to be 24.6 years. From Table 14 in "Population Movement in 1947" (Befolkningsrorelsen ar 1947–SOS, 1950), the mean age for married childbearers is calculated to be just under 29 years. The median age of the parents of children born in wedlock is calculated from Table 18 in the same survey to be 32.7 years. Late marriages are likely to be connected with late sexual debut and, accordingly, possibly stronger sexual taboos. Older parents may have greater difficulty tolerating behavior in children involving sexual taboos.

The number of patients born out of wedlock probably does not exceed the mean frequency in the Swedish population, which is perhaps surprising in view of the importance accorded by analysts in particular to the identification process in normal psychosexual development. However, the frequency of children born in wedlock who grew up as the only son or the only child is much higher than in the population in general. The 1935/1936 census (SOS, 1939) reported that 10.94% of Sweden's population born between 1900 and 1935 grew up as the only child. Slightly more boys than girls were born, but an estimation of

frequency of the only son in the population is 6% (this is not an underestimation), whereas 15% of the present patients grew up as the only child. This differs significantly from the normal population. Patients who were the only son displayed a higher incidence of premature ejaculation than other patients. This remarkable primary group relationship has to my knowledge not been reported before. It cannot be explained by the high incidence of higher age in the parents of patients. The circumstance that old parents usually have more children than young ones should, on the contrary, compensate for the over-representation of patients who were the only son of old and hitherto childless parents.

The older patients suffered mainly from impotence. A high incidence of impotence in older patients has been reported in several studies. According to Kinsey *et al.* one-fourth (27%) of the men interviewed were impotent at 70; at 75, more than half (55%) were impotent. Against this background, it is remarkable that only 19% of the patients were more than 52 years old.

A similar age distribution was found by Carlsson and Westrin (1969) in the patients at RFSU Clinic in Göteborg. It should be pointed out here that Simpson (1950) maintains that if the ability to satisfy the female partner is included in the definition of impotence, 50% of all men would presumably be classified as impotent. For older men seeking help, impotence often made its debut when a new, often much younger partner was acquired in conjunction with the death of a spouse or a divorce. These men had most often been sexually abstinent for a long time because of the wife's illness or unwillingness to engage in sexual intercourse.

Technical and economic occupations dominated among the patients. This was also true of Dahlin's series. Engineers comprised 16.5% of the patients, whereas the corresponding figure for the total population was 4.58% according to the population and housing census of 1965 (Folk- och bostadsräkningen 1965–SOS, 1969) and 5.46% according to a sample drawn by means of the central population register of the Central Bureau of Statistics which contains basic demographic and social data on every individual born on the fifteenth of any month, any year, irrespective of place of birth or place of residence. This is, in effect, a 3.3% probability sample of the entire Swedish population (Carlsson, 1958).

The reason may be that technically and economically trained persons think more technically and in a more organ-oriented manner (Dahlin). It is also conceivable that the choice of occupation is influenced by a factor connected with the psychosexual function. Only a few comparable investigations are published concerning conditions in Sweden. Mellgren's (1967) series comprising patients with premature ejaculation displayed a somewhat dissimilar distribution of occupations: "Bank employees, clerks, watchmakers, teachers, fine mechanics, engine drivers, tailors, engineers." Mellgren, who does not give any statistical figures, elucidates the over-representation of these occupations with the circum-

stance that they require "great concentration." However, the relatively heavy representation among the present patients of occupations which place a greater emphasis on flexibility and experience in making outside contacts than on accuracy, e.g., the salesman and shop assistant, contradicts the claim that concentration is one explanation of psychosexual disorders in certain occupational categories. Mellgren's series consists of 40 patients, and this seems to be too small a group to permit any conclusion about the occupational structure of patients with premature ejaculation, and it includes eight different "predominant" occupations. In a report from the RFSU Clinic in Göteborg (Carlsson and Westrin, 1969), the patients were not differentiated in such a way that it is possible to identify the frequency of technical and economic occupations. Workers with or without vocational training comprised about 50% in that series, which is about 12% more than in this series, while high-school educated people occurred in about the same frequency, i.e., 10 and 13.5%.

The psychiatric clinics in Stockholm do not report on the socioeconomic status of patients, which is why no comparison can be made with any general Swedish psychiatric series. In England, higher social classes were over-represented among patients with psychosexual problems as compared with those who were seeking aid for general psychiatric disorders. (Johnson, 1965; Cooper, 1968*a*, *b*).

REFERENCES

Abraham, K. (1927). *Ejaculatio praecox,* The International Psychoanalytical Library 1949 (Jones, E., ed), No. 13, Hogarth Press, London.

Blend, D. (1967). Sex and its problems. IV. The impotent male. *Practitioner* 198/1186: 589-596.

Carlsson, B., and Westrin, C. G. (1969). Klientelet pa en sexualrådgivningsbyrå. *Soc. Med. T.* 46: 10, 514-520.

Carlsson, G. (1958). *Social Mobility and Class Structure,* CWK Gleerup, Lund.

Cooper, A. (1968*a*). "Neurosis" and disorders of sexual potency in the male. *J. Psychosom. Res.* 12: 141-144.

Cooper, A. (1968*b*). A factual study of male potency disorders. *Brit. J. Psychiat.* 114: 719-731.

Dahlin, O. (1969). Erfarenhet av sexuell radgivning. Manuscript.

Johnson, J. (1965). Prognosis of disorders of sexual potency in the male. *J. Psychosom. Res.* 9: 195-200.

Johnson, J. (1968). *Disorders of Sexual Potency in the Male,* Oxford University Press, Oxford.

Kinsey, A. C., Pomeroy, W. B., and Martin, C. E. (1948). *Sexual Behavior in the Human Male,* Saunders, Philadelphia.

Korpi, W. (1964). *Social Pressure and Attitudes in Military Training,* Almqvist and Wiksell, Stockholm.

Levie, I. H. (1953). Disturbances in male potency. In Pillay, A. P., and Ellis, A. (eds.), *Sex, Society and the Individual,* Bombay.

Lidberg, L. (1970). Somatiska sjukdomar vid impotens och ejaculatio praecox. *Nord. Psykiat. T.* 24: 293-298.

Masters, W. H., and Johnson, V. E. (1966). *Human Sexual Response,* Little, Brown and Co., Boston.

Mellgren, A. (1967). Treatment of ejaculatio praecox with thioridazine. *J. Psychoter. Psychosom.* 15: 454-460.

Noy, P., Wollstein, S., and Kaplan-de-Nour, A. (1966). Clinical observations on the psychogenesis of impotence. *Brit. J. Med. Psychol.* 39: 43.

Official Statistics of Sweden (1965). *Population and Housing Census in 1965,* Statistiska centralbyran, Stockholm.

Schapiro, B. (1943). Premature ejaculation. *J. Urol.* 50: 374-379.

Simpson, L. S. (1950). Impotence. *Brit. Med. J.* i: 692-697.

Statistique officielle de la Suede (1939). *Recensement de la population en 1935/36,* Sarskilda Folkrakningen 1935/36. VI. Partiella Folkrakningen i mars 1936: Barnantal och doda barn i aktenskapen, 1939, P. A. Norstedt & Soner, Stockholm.

Statistique officielle de la Suede (1950). *Mouvement de la Population en 1947* (Sveriges Officiella Statistik. Befolkningsrorelsen ar 1947), P. A. Norstedt & Soner, Stockholm.