Human sexuality in physical and mental illnesses and disabilities

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Chapter Two

Internal Medical Conditions

Cardiovascular Diseases / Diabetes and Other Endocrine Disorders / Renal Failure / Cancer / Obesity
Cardiovascular Diseases


The purpose of this study was to examine various aspects in the sexuality of 100 women with acute myocardial infarction. A control group consisted of 100 patients hospitalized for other reasons. Results and conclusions are presented and discussed.


A panel of authorities participating in a seminar on Counseling the Cardiac Patient on Work and Sex answers various questions relating to sexuality in heart disease. Questions answered include: (1) How does the physiological cost of sexual activity compare with other daily work activities? (2) How long is it necessary to forbid sexual activity following onset of cardiac illness? (3) What factors determine success in returning to sexual activity following a heart attack? (4) Is sudden death during sexual intercourse a realistic danger? (5) Can graded sexual activity be utilized for the purpose of increasing collateral circulation in patients? Also discussed are some guidelines for the counseling of cardiac patients in sexual matters.


The authors present the results of a follow-up study examining adjustment of former myocardial infarction patients. Results show that although most of the patients resumed a normal life, there was a sharp
decrease in the frequency of their sexual intercourse. Reasons for this change were: decrease in sexual libido and desire, depression, anxiety, wife’s fears, patient’s fear of sudden death during intercourse, fatigue, angina, and impotence.


The main purpose of this book is to offer information about sexual and emotional aspects of heart disease. Topics discussed include the sexuality of the middle-aged man, sexual problems and heart disease, pregnancy and heart disease, and others.


This is a report of a study aimed at the examination of the association between sexual impotence and vascular insufficiency. Some of the patients examined were suffering from pelvic vascular insufficiency resulting from vascular disease. Results and conclusions are presented and discussed.


To fill the gap in needed services, a sex counseling program in cardiac rehabilitation was developed. Aspects of this program and reactions of patients and their spouses are discussed along with recommendations for further investigation of this process.


Sexual difficulties, fears, and anxieties associated with cardiac disorders are discussed in light of the physiology of the sexual response cycle. Also presented are specific suggestions for office counseling and advice by a physician.


This article discusses various myths and misconceptions held by both cardiac patients and health-care practitioners regarding sexual activity. Information is presented in regard to heart rate during the
sexual response cycle, and to training the heart to tolerate a higher level of work load. It is recommended that the topic of sex should be discussed with the patient as soon as his condition stabilizes.


In this article the author discusses concerns facing the cardiac patient. Cardiac illness brings many questions and fears to the patient regarding sexual functioning. Many patients fear the possibility of dying during intercourse. The author feels that through open discussion with the nurse or physician, the patient can become more knowledgeable about his personal condition and alter his activity to agree with his heart problems and thus alleviate the fears and anxiety associated with sexual intercourse. The author also discusses various aspects of sex counseling with cardiac patients, outlining specific precautions for the patient before or during sexual intercourse. He concludes that as soon as the cardiac patient can resume his former life patterns, sexual relations can also be resumed.


The purpose of this study was to obtain data to provide a base for counseling postcoronary patients regarding sexuality. The study compared the sexual activity of postcoronary and highly coronary-prone subjects, identified modifying factors compromising optimal sexual activity, and compared physiologic changes during sexual coitus to changes occurring during other activities. Various means of data collection were used to obtain a full psychophysiologic and sexual profile of each patient (n=91), and EKG tracings which compared heart rates and changes during sexual activity and other activities were obtained. Many factors which could modify sexual activity were explored. The results indicate that sexual activity in the postcoronary patient is based on an interaction of pre-illness status and the direct and indirect effects of heart disease. It was found that sexual activity decreased markedly in subjects with higher blood pressure, more passive dependency, and lower incomes. There was an increase in sexual activity with decrease in cholesterol. The physiologic stress of coitus was found to be minimal. The authors concluded that sexual activity depends on: (1) sexual drive and performance in earlier life; (2) the effects of aging; (3) the spouse's health, attitudes, and decisions; (4) physiologic factors after
myocardial infarction; (5) cardiovascular function prior to myocardial infarction; and (6) response to medical intervention to enhance heart function.


This paper presents the results of a study which examined sexual functioning and activity in postcoronary patients (n=91). A subsample of 14 patients was monitored by EKGS during work and sexual activity. Results of the study show a decrease in sexual activity in these patients after myocardial infarct. Other results are discussed and conclusions and specific recommendations are presented.


The author describes and discusses cardiac response and expenditure during sexual activity in patients with hypertensive disease. Also presented are the effects of antihypertensive drugs on sexual behavior. Finally, specific measures to give protection from hypertensive complications are outlined.


The need for the physician to counsel the coronary patient on sexual activity is the major theme of this article. The authors assert that in determining when sexual activity can resume after the coronary episode the minimum considerations should be the extent of recovery, the physiologic costs of sexual activity, and the level of precoronary sexual activity. If the patient can climb two flights of stairs without difficulty, he is usually considered to be able to engage in sexual activity. Both the patient and his spouse should be counseled on when sexual activity can be resumed and on alternate positions for sexual intercourse in order to keep stress factors at a minimum.


The results of a study aimed at the examination of sexual behavior patterns in male hypertensive patients (n=88) are presented and dis-
cussed. It was found that 50 percent of the patients had decreased sexual potency. The patients attributed this to their drug therapy. While no one specific drug was blamed, the incidence was higher in patients who were severely hypertensive and on larger doses of all drugs. The author suggests that questions related to sexual activity in males should be included in all questionnaires about hypotensive drugs.


After the immediate life-threatening crisis of cardiac illness has subsided, the patient shifts his energies to other concerns. Two of these concerns are returning to work and resuming sexual activities. The latter seems to be the most difficult for the patient and the health professionals to handle. The author discusses ways of facilitating communication between nurse and patient in dealing with the patient's sexual concerns. The nurse or physician should include the patient's spouse or usual sex partner whenever plans for discharge are made. The patient's sex partner usually has fears and concerns of his or her own that need to be discussed. Fears or concerns of either the patient or the patient's sex partner that are not openly discussed may hamper optimal recovery of the patient.


This article summarizes a seminar discussion dealing with counseling the cardiac patient regarding work and sexuality. The actual physiologic cost of sexual intercourse is reported to be equivalent to that of climbing one flight of stairs at a medium pace. At orgasm the heart rate usually averages between 120 and 140 beats per minute in most of the postinfarction patients studied. A physical conditioning program usually improves sexual activity in both quantity and quality. The physician must evaluate the physiological as well as the psychosocial aspects of the patient before making a rehabilitation program recommendation.


The relationship between peripheral vascular disorders and sexual functioning is discussed in this article. The effects of therapy on sexuality are also discussed.

The occurrence of sudden death during sexual intercourse as a result of a coronary occlusion is discussed. The viewpoints of four authorities are presented.


Essential questions asked by cardiac patients regarding their sexuality are discussed in this article. Also presented are numerous guidelines for sexual intercourse which could help patients minimize the work load on the heart.


This article discusses the effects of stroke on sexual libido and functioning. The average age at stroke is approximately 70 years, and the patient is likely to have preexistent health problems such as diabetes, hypertension, or coronary artery disease. Also, the patient may have taken either pre- or post-stroke medication which tends to decrease libido and limit sexual functioning. Other causes of sexual dysfunction associated with stroke and some suggestions for counseling are presented.


To elicit information relating to preexisting sexual practices as well as to the dysfunctions superimposed by hypertension and its therapy, the authors examined 50 hypertensive patients. Results of this study and conclusions are presented and discussed.


Anxieties about the association between hypertension and cardiovascular disease result in many cases of sexual dysfunctions and difficulties. The author discusses these problems and presents some specific suggestions for office counseling by a physician. Specific topics discussed include blood pressure and sexual coitus, effects of antihypertensive medications on sexual functioning, and counseling the patient.

Sexual activity should be frankly discussed with every patient suffering from coronary disease. These authors present their opinions regarding the sex counseling and advice a coronary patient should receive from his physician. In general, there is agreement among the authors that when a patient is fully recovered from a heart attack he “may lead a reasonably normal life” which includes sexual activity.


The effect of heart disease on the patient’s sexual functioning and behavior is discussed. Physiological changes during sexual intercourse are also considered.


Careful and thoughtful psychosexual counseling and advice should be an integral part of the physician’s work with cardiac patients. In most cases, sexual dysfunctions in patients are a result of psychosocial factors caused by the illness and not the result of the illness per se. The author discusses the impact of these factors, which she calls the “As and Ds of sexual dysfunction in heart disease.” These are: anxiety, anger, aging, depression, dissociation, deliberate sexual control, and drugs. It is important to attempt to prevent sexual dysfunction as a result of these factors by providing the cardiac patient with adequate counseling before he or she leaves the hospital.


Concerns and anxieties about sexual activity and the possibility of heart attack during sexual intercourse is one of the areas of emotional reactions to cardiac diseases discussed in this paper. These fears may be shared by the patient’s spouse, and if not openly discussed may result in complete avoidance of physical contact between the anxious couple. Sexual dysfunction, usually secondary impotence, may occur as a consequence of the patient’s anxiety over his sexual performance or his cardiac situation and life. The author concludes that “it is wise to suggest some relaxed sexplay for the couple as an alternate to coitus
until he is reassured about the quality and duration of his erections.” Also effective is an open and frank discussion with the couple which allows them to raise questions and voice concerns and anxieties.


Autonomic, emotional, and chemical factors associated with possible sexual dysfunctions in stroke patients are discussed in light of existing research and clinical knowledge. Some of the sexual dysfunctions are psychogenic in origin. Overwhelming fear and ongoing anxiety about recurrent stroke, anxiety over sexual performance, unresolved guilt feelings associated with the stroke, and depression are some psychological causes of dysfunctional sex. The author suggests that an explicit and frank discussion of sexuality with both the stroke patient and his or her partner “can make the most profound change in the way the couple either endures their separate loneliness or live out their remaining years in optimum closeness.”


A panel of five physicians discuss their clinical opinions in regard to counseling the postcoronary patient about future sexual activity. A general consensus is that sexuality needs to be discussed openly with every patient suffering from coronary disease. One opinion presented is that sexual intercourse may be resumed in six to eight weeks after the attack if no subsequent significant anginal pains have occurred. The preferable time for intercourse is in the morning when the patient is rested.


Reflecting upon their clinical experience and a review of the literature, the authors discuss the sexual aspects of aging with special emphasis on cardiac problems. Expanding upon results of research on sexual response in older people, the authors abolish common myths and misconceptions by proving that older persons have sexual interests and ability. Indicating that sex does not put an excessive strain on the heart, they present concrete sexual stimulation exercises for the cardiac patient and his or her spouse. They devote a chapter to a discussion of the resumption of sexual activity following a heart attack and other heart diseases. This is followed by a discussion of the role of the...
spouse of the cardiac patient in the sexual adjustment of the couple. Finally, the authors address themselves to the sexual problems of older single, widowed, or divorced individuals and assert that "the game-playing nature of traditional courtship could be abandoned in the later years in favor of more honest communication."


The authors report that of 22 men treated for hypertension with guanethidine, 5 experienced retrograde ejaculation and 4 others became sexually impotent. In the case of retrograde ejaculation, an orgasm occurs and the semen reaches the prostatic urethra, but it then passes into the bladder rather than to the outside. This condition results from failure of the vesical neck to close during orgasm. Inasmuch as closure of the vesical neck is under control of the sympathetic nervous system, the development of retrograde ejaculation following a chemical sympathectomy produced by guanethidine is understandable.


The authors report the results of a study they conducted with 65 wives of patients with myocardial infarction. The initial impact, the reaction after hospital discharge, and the adjustment one year after the onset of illness are discussed. Data showing the frequency of sexual intercourse before and after the illness are also presented. Many wives reported that the frequency of sexual coitus had been decreasing as they became older and that the illness only accelerated this trend. Nine wives expressed concern and anxiety about the effect of sexual activity on their husbands. By six months after the onset of the illness all but one of these nine couples had resumed sexual activity. The authors conclude that their findings confirmed the psychological difficulties experienced by wives of myocardial infarction patients reported by previous studies.


This is a guide to office counseling related to the resumption of
sexual activity after myocardial infarction. The author identifies and discusses the factors causing alteration in sexual functioning and activity following a myocardial infarction. These factors include previous sexual pattern, physiological aspects, self-image, and fear of precipitating another heart attack.


Sexual aspects and concerns associated with cardiovascular diseases, and the spouse's role in the sexual adjustment of the patient, are discussed in light of clinical and research findings.


The incidence and nature of death during coitus due to cardiac disorder is discussed in light of the findings of clinical studies and observations.


The aim of this study was to examine sexual functioning and activity in patients who had had myocardial infarction one to nine years prior to the study. The interval from myocardial infarction to first sexual intercourse averaged three months. Results of the study showed that a third of the patients resumed their normal pattern of sexual activity. Two-thirds had a marked and lasting reduction in the frequency of sexual intercourse. Impotence was reported in 10 percent of the study sample. These patterns bore no relation to the age of the patient, or to the severity of the heart disease. It was suggested that changes in sexual activity and pattern resulted from fear and lack of adequate advice and counseling. The authors urge physicians to be more specific in their recommendations for postmyocardial infarction patients.


The impact of cardiac disease on sexual function and behavior of patients and the role of the practicing nurse in alleviating sexual prob-
Problems and concerns are the topics discussed in this paper. Attention is given to the physiological effects of sexual intercourse on the cardiovascular system, the psychosocial aspects of cardiac disease, and to the implications for sex counseling. If the nurse is to be effective in this role, she has to assess her own attitudes toward sexuality, develop interpersonal skills necessary to discuss sexuality freely, assess and increase her sexual knowledge, be able to assess the patient's sexual concerns, and explore the role of the nurse in the intervention of sexual concerns of patients.


Due to limited sex counseling and advice provided by physicians, cardiac patients usually act according to their limited knowledge, fears, myths, and misconceptions. This may lead to unwarranted decrease in sexual activities, even to the point of complete abstinence. The author discusses sexuality in cardiac patients in light of research and clinical data accumulated in this area. The physiology of the sex act is described with special attention given to changes that occur in the heart function during the sexual response cycle in coitus and masturbation. Finally, some specific implications for counseling are identified and discussed. The author concludes that when the cardiac "patient has returned to mild to moderate physical activity, he can also return to the level of sexual activity he was experiencing prior to the onset of cardiac difficulties. Patients should not be deprived of assistance in this area of their rehabilitation."


Sexual implications of cardiac disease in middle-aged patients are discussed. Specific topics presented include the male sexual response cycle, depression in patients and its effect on sexuality, spouse's role, and the role of the nurse in alleviating the patient's concerns.

Doppler measurements of penile blood pressure and penile pulse measurements were taken from 15 impotent diabetics and 29 controls. The pulses were palpable in all subjects in the control group but not in 6 diabetic patients. While the penile blood pressure was obtainable in all control subjects it was not obtained in 2 diabetics. The author concludes that “using the penile pulse data and a comparison of the penile with the brachial systolic pressures, 2 or possibly 3 grades of penile ischemia are definable, providing a measure of pelvic vascular insufficiency.”


This is a detailed clinical case report of a 33-year-old male patient who had a combined syndrome of depression-hyposexuality and alopecia (excessive loss of hair). The authors point out the similarity of this syndrome to some other characteristics of endocrine diseases. Although they refrained from indicating the causation of the syndrome described in their paper, the authors do suggest that it might have an endocrine origin.


The symptoms, etiology, and sexual aspects of hypospadias and epispadias are discussed in this article.


There is a high incidence of impaired sexual function among male diabetic patients. This study examined plasma testosterone in 10 diabetic patients. Results indicate that in patients affected by sexual dysfunction, plasma testosterone levels are maintained, at least until the eighth decade of life.
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The author studied 63 diabetic patients, 8 of whom complained of sexual dysfunction. Results show a decrease of 17-ketosteroids in the younger group.


This paper discusses the interplay between endocrinopathies and psychosexual disturbances. The authors suggest that "many endocrinopathies produce serious psychological disturbances, either directly or via their secondary effects." The authors discuss various endocrine disorders associated with childhood, adolescence, and adulthood, e.g., precocious puberty, acne, polycystic ovarian disease, menstrual irregularity, adrenal hyperactivity syndrome, Klinefelter's syndrome, infertility, menstrual dysfunction, menopause, and other abnormalities. The psychological and sexual implications of each disorder are identified and discussed. Commentaries by two authorities follow this presentation.


The main purpose of this study was to examine the social and psychosexual development and personality function in a group of male patients (n=13) with chronically delayed spontaneous puberty attributed to hypogonadotropinism. In five cases this condition was associated with verified hyposmia (Kallmann's syndrome). Patients revealed an inhibition or lack of sexual interest and arousability alone or with a sexual partner. This absence of sexual interest and activity remained following initiation of sex hormone treatment. This led the authors to conclude that "one may speculate that it is a matter of generalized inhibition secondary to histories of prolonged infantilism and apprehension about nondevelopment rather than the simple absence of hormonal puberty."

According to the author, sexual dysfunction occurs with similar frequency in diabetic males and females. A careful evaluation of sexual functioning in the patient should be conducted. The author suggests the following steps in evaluation: obtain a complete sex history and physical examination in an attempt to distinguish psychological from physiological dysfunctions; inquire about intermittent sexual dysfunction; look for signs of depression, anger, fear, and anxiety—all can cause sexual dysfunction; inquire about medication and alcohol use; determine if the patient’s diabetes is under control; look for endocrine abnormalities or organic diseases. After eliminating all these possibilities, the physician should consider “diabetic sexual dysfunction.”


This brief guide to office counseling concentrates on a discussion of the sexual dysfunctions associated with diabetes in male patients. Types of diabetic impotence and other dysfunctions are described along with their causes, and specific guidelines for counseling by a physician are presented.


The purpose of this study was to examine a group of male diabetics with autonomic neuropathy to determine the possible usefulness of testicular pain sensation. The subjects were 32 male diabetics with autonomic neuropathy. The most common symptom of autonomic neuropathy was impotence. In 14 of the subjects it was the only symptom. In 17 patients impotence was accompanied by other signs of autonomic neuropathy, such as postural hypotension, intermittent nocturnal diarrhea, and gastric fullness or delay in emptying. Only 1 subject denied impotence. The mean age of the subjects was 48 years and the average duration of diabetes was 17 years (range 2–33 years). All but 4 of the subjects were using insulin. The results showed that 14 subjects had normal responses to testicular pain. Of the rest, 2 subjects had no response and 6 subjects had diminished response to testicular pain. Of the 14 subjects with impotence alone, only 2 had diminished testicular sensation, whereas of the 18 subjects with other features of autonomic neuropathy, 11 had absent and 5 had diminished testicular sensation. The subject who reported no impotence had normal testicu-
lar pain sensation. The authors concluded that absent or diminished testicular sensation correlated well with objective evidence of autonomic neuropathy. Those subjects with impotence alone usually had a normal testicular pain response. Subjects with other signs of autonomic neuropathy tended to have abnormal pain response.


Addison’s disease refers to primary adrenal insufficiency. This brief article presents the symptoms, diagnostic tests, and treatment of this disease. Sexual problems, including impotence and decreased sexual libido, are not infrequent in patients with Addison’s disease. The author discusses various therapy modalities in the treatment of sexual dysfunctions associated with this disease.


This article presents various aspects of sex, eroticism, and social behavior found in nine postpubertal male hypopituitary patients without hypogonadotropinism. Results show that in the patients studied, sexual inertia was expressed as a relatively low frequency of erection, ejaculation, masturbation and fantasy, as well as decreased incidence of dating and erotic behavior. A tendency toward social isolation was also observed.


A long list of causes for endocrine impotence is presented, with diabetes mellitus given the strongest emphasis. The relationship of testosterone to potency and impotency is also discussed, with supportive data. A sex history taken from both partners and a thorough physical examination are important before treatment can begin. The steps for treatment where an endocrine disorder is present include replacement measures to restore physical health, and psychophysiological therapy aimed at the impotence. There is better success if both types of treatment are done by the same person. In the absence of an endocrine disorder, psychophysiological treatment should be initiated.

Endocrine disturbances associated with sexual impotence are discussed and suggestions for treatment are presented.


Psychological, social, and sexual aspects of idiopathic sexual precocity are discussed and specific suggestions for treatment, counseling, and sex education are presented.


Sexual dysfunctions in diabetic patients were examined. The authors conclude that the occurrence of impotence could not be related to either pituitary or testicular dysfunction.


An underlying neurologic factor associated with impotence in diabetes was suggested by the fact that penile erection depends on the autonomic nervous system, which is frequently involved in diabetic neuropathy. This study examined this neurogenic basis of impotency in 45 impotent diabetic patients whose average age was 43.2 years. Seventy-five percent of the patients had had diabetes for less than 10 years. The control group consisted of 30 male diabetic patients who were sexually potent. Results of an extensive examination revealed that of the 45 impotent patients studied, 37 showed neurogenic vesical abnormalities and 38 had neuropathy. In the control group, 3 of 30 patients had bladder involvement, and neuropathy was detected in 6 patients. Results of a random survey of 200 diabetic male patients indicate that 59 percent were sexually impotent, and 82 percent of these impotent patients had neuropathy. Only 12 percent of the potent patients showed neuropathy. Plasma testosterone levels were also examined to discover any possible endocrine cause for the diabetic impotence. Results showed normal testosterone levels. Testosterone therapy produced no successful results in patients. The author concludes that the results of his study "imply a significant neuropathic factor in diabetic impotence and minimize an endocrine basis."

Impotence in male diabetic patients is far more frequent than in nondiabetic persons. In this article, the author discusses the effect of diabetes on male potency. The emphasis in discussion is on the endocrine and neurologic factors underlying impotence. The author concludes that “the findings of normal plasma testosterone values and the completely negative response to the use of testosterone in full measure are strong arguments against the significance of endocrine factors in the pathogenesis of diabetic impotence.” He adds that his studies imply that impotence in the diabetic male is based on neurologic factors, and is usually associated with neurogenic bladder involvement.


The effect of diabetes on female sexuality was studied in 100 patients. This group included relatively equal numbers of women with and women without neuropathy. Results show that 44 of the 54 patients with neuropathy had normal libido and orgasmic reaction. Only 7 women in this group indicated diminished libido and orgasmic responsivity. Of the 46 patients without neuropathy, 38 reported normal libido and orgasmic reaction, 6 showed diminished responses, and 2 reported absent libido and orgasmic responsivity.


This paper presents five case reports of retrograde ejaculation associated with diabetes. The reports document this syndrome as a diabetic autonomic neuropathic manifestation, and indicate the sequential developments in relation to its pathogenesis.


Physical diseases, particularly of an endocrinologic nature, may affect sexual functioning and development. This brief guide to office counseling identifies some of these diseases and discusses sexual problems associated with each of them. The medical conditions discussed include acromegaly, pituitary dwarfism, pituitary tumors, extreme obesity, hyperthyroidism, parathyroids, and others.

In searching for a neurological lesion of the nerves that control erection, the authors conducted this histologic study to examine the nerve fibers of the corpora cavernosa of the penis in a group of impotent diabetic males. Autopsies were performed on five impotent diabetics, mean age 51, with an average duration of diabetes of 9.6 years. Results of this study and some conclusions are presented and discussed in this article. The authors conclude that their study lends strong support to the opinion that sexual impotence in diabetics is due to neurological lesion of the nerve fibers that control erection.


In order to study sexual functioning in male diabetics, the authors examined the plasma concentration of testosterone, the biosynthesis of androgens, and testicular morphology in seven male diabetic patients who were sexually impotent. For comparative purpose these examinations were performed also in a group of five paraplegic patients. Results of this study and some specific conclusions are presented and discussed. The authors conclude that "the present study suggests that the impotence and the testicular abnormalities found in diabetics may be secondary to a lesion of the autonomic nerves."


To investigate possible sexual dysfunctions in patients with hypoglycemia, the author reviewed 25 case histories of patients referred to him. This article presents and discusses the results of this review. The author suggests that the patient's evaluation should include a comprehensive sex history, as sexual conflicts and difficulties may be an important source of the patient's discomfort.

The physical, psychosocial, and sexual aspects of hyper-adrenocorticalism are identified and discussed. This condition is due to an excess of adrenocortical hormones, which occurs more frequently in the female than in the male. In the female, this condition leads to defeminization, i.e., amenorrhea, breast atrophy, decreased pelvic adiposity, acne, and hirsutism. In the adult male, acne and increased muscle strength and sex drive occur initially, followed by weakness and impotence.


The author was confronted with the problem of deciding “whether, in the presence of clinical evidence of oblitative vascular disease in the lower limbs, impotence could be ascribed to obstruction to blood flow in vessels supplying the penis.” To examine this problem, penile blood pressure of impotent subjects was compared to that of potent healthy male subjects. Some of the impotent subjects were diabetic patients. The author concludes that the results of the study indicate that “obstruction to blood flow was identified as a cause of impotence in patients with little other evidence of peripheral vascular disease.”


In retrograde ejaculation, an orgasm occurs and the semen reaches the prostatic urethra, but it then passes into the bladder rather than to the outside. The authors have extensively studied four patients who were experiencing retrograde ejaculation. Clinical studies indicated that each patient had experienced a functional sympathectomy secondary to diabetic neuropathy, and it is the authors' opinion that this complication of diabetes was the etiologic basis for the retrograde ejaculation. These four case studies are presented and discussed. In all cases, diabetic visceral neuropathy appeared to result in a disturbance of the sympathetic nerves supplying the bladder. This in turn prevented closure of the vesical neck and allowed retrograde ejaculation of semen.


The author presents a case history of a 33-year-old patient with a long-standing case of obsessional neurosis with emaciation, sexual impotence, and hypogonadism. Four months after he underwent pre-
frontal leucotomy he was obese, with gonads of normal size, and experienced adequate sexual functioning and activity.


The authors examined 28 diabetics, 18 of whom complained of diminished sexual potency. In 9 of these patients there was no ejaculate, and in 4 patients the ejaculate volume was less than normal. The sperm count was diminished in 5 patients, and in 14 patients there was abnormal motility.


This article presents the results of a study aimed at the examination of sexual function in diabetic women (n=125). Results show that 35 percent of the patients had complete absence of orgasmic response during the year preceding this study, whereas only 6 percent of nondiabetic controls reported nonorgasmic response during the same period. The author urges further research in this area.


The purpose of this study was to obtain further data on sexual dysfunction in male diabetics. Subjects were 175 men, 18 to 83 years of age, with diabetes mellitus. These men were interviewed during outpatient visits. The study involved obtaining a sex history and a medical history, performing a physical examination, and obtaining lab studies. The sex history included questions covering sexual distress, the mode of impotency, the onset, duration, frequency, and degree of impotence, and the current existence of intact neurovascular function. Results show that of the 175 men, 85 (48.6 percent) were impotent. No relation was found between duration of diabetes and impotence, which was usually gradual in onset. Incidence of neuropathy was found to be significantly higher in impotent males. The authors assert that the pathophysiologic mechanism of impotence in diabetic men is unclear. Since there is no known therapy for these men, the physician must first rule out curable impotence. The authors suggest that counseling of both husband and wife is vital, especially in relieving tension and anxiety for the incurably impotent diabetic male.

This is an extensive discussion of the effects of diabetes on sexual potency and functioning of male patients. A comprehensive review of relevant literature is presented and conclusions are drawn. Tables showing the percentage of impotent diabetic patients in different studies and the prevalence of impotence in different age groups of diabetic and nondiabetic subjects are presented and discussed. Other topics covered are the pathogenesis of impotence, failure of ejaculation, endocrine factors in diabetic impotence, hystological and seminal fluid examination in diabetics, vascular aspects of impotence, and impotence on a psychogenic basis. The authors conclude that “although impaired sexual function in diabetics is a frequent and serious complication, the pathogenesis is poorly understood and the therapy of this condition leaves much to be desired.”


According to the authors, the endocrine basis in organic impotence is by far the most significant factor. This article examines the sexual implications of nondiabetic endocrinopathies that can result in impotence. The authors suggest that impotence in patients with endocrinopathies may be reversible by correct diagnosis and early therapy. A wide variety of endocrinopathies associated with sexual dysfunctions is presented and discussed.


The authors found that in five of seven diabetics with diminished sexual libido and potency there was a significant decrease in the level of 17-ketosteroids.


This article presents and discusses the results of a study aimed at the examination of the psychosexual function of four patients with anorchia and four patients with nonfunctional testes. A case study of a patient with bilateral anorchia, who was functioning satisfactorily in sexual coitus for over two years before treatment, is presented in de-
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Analysis of the data obtained shows a wide range of erotic imagery and sexual behavior in the subjects. Testosterone treatment caused an increase in the level of sexual activity in all subjects, though to different degrees.


The purpose of this report was to present the findings of an investigation of psychosexual development and sexual behavior of 18 precocious boys. Results show that, generally, “psychosexual development, in the precocious boys under study, clearly was not an automatic byproduct of the precocious pubertal appearance of sex hormone.” Distinguishing psychological characteristics of the study subjects were a tendency to high IQ, increased energy expenditure, early occurrence of the capacity for frankly sexual imagery in dreams, and early establishment of the capacity for sexual excitation by visual imagery and perception as well as by tactile sensation.


The authors discuss various aspects of psychosexual development, sexual behavior, eroticism, and social development in postpubertal male patients diagnosed as having hypopituitarism secondary to the surgical removal of a pituitary tumor. Data collected and analyzed include information on erection, ejaculation, masturbatory behavior, erotic imagery, sexual intercourse, dating, socialization, and love. Problems of case management are discussed and suggestions for counseling are presented.


Fifteen females with precocious puberty were followed and examined. Results reported in this paper relate to the subjects’ intellectual levels, school achievements, friendship choices, play interests, moods, maternalism, masturbation and sex play in childhood, romantic and erotic imagery and dreams, sexual intercourse, marriage, and preg-
nancy. Also reported are findings describing body image of the patients. Suggestions for counseling are presented.


Morphological changes with age in the seminal vesicles and vasa deferentia of diabetic and nondiabetic patients were examined and compared in the study presented in this article. Results and conclusions are discussed.


The purpose of this study was to examine human figure drawings of six postpriapism sexually impotent patients and one postpriapism sexually potent patient. Subjects were also interviewed for a psychosexual assessment of genitopelvic eroticism. Results show that "all the impotent patients indicated their sexual inadequacy and incompetence to satisfy their partners in sexual intercourse." The human figure drawings did not present any sign that could reveal that impotence was the patients' specific disability.


Of special interest is a section in this article discussing various medical conditions and diseases associated with organic impotence, e.g., diabetes mellitus, multiple sclerosis, pernicious anemia, and others. The authors also discuss the etiology, diagnosis, and endocrine therapy of impotence resulting from these conditions.


Sexual functioning in 175 male diabetic patients was studied. Of these patients, 40 percent had lost sexual potency. Other results are discussed.

The author indicates that this brief presentation “overviews what little has been done in the specific study of diabetic impotence, [and] reveals many uncertainties regarding the actual mechanisms responsible for the symptom.” Three clinical case studies are presented to illustrate the role of various psychogenic factors in the development of a sexual dysfunction in the diabetic male. The author suggests that it is very difficult to make a diagnosis for organic impotence in a diabetic.


The author describes disorders of production of spermatozoa and of seminal fluid in ten of eleven diabetic patients he examined.


This study examined reproductive histories of 198 diabetic men attending diabetes clinics. Twenty-five percent of the sample 30 to 34 years of age were sexually impotent. The incidence gradually increased with age so that by 50 to 54 years 53.6 percent were impotent. The incidence of impotence was not related to the age of onset of the illness, its duration, its severity, or the presence of vascular or neurological complications associated with the diabetes. There were no significant differences between the study and control groups in regard to incidence of conceptions, premature births, stillbirths, malformations, sex ratio of the offspring, and birth weights of offspring.


Impotence occasionally seems to be the first symptom presented by a diabetic patient when he first seeks medical aid. The relationship between diabetes and sexual functioning and behavior is discussed in light of the findings obtained by examining 198 diabetic patients.

A sample of 198 diabetic males was studied regarding the frequency of difficulties they experienced in obtaining and maintaining erections. Impotence was found to occur at an earlier age and more frequently among the patients than in the general population. The incidence of impotence in diabetics in the age group 30 to 34 was two to five times higher than in the population studied by Kinsey and his associates. The incidence gradually increased with age, to 53.6 percent for diabetic men 50 to 54 years of age. Thirty percent of those who became impotent did so within one year after the clinical recognition of their illness. Sixty percent became impotent within five years of the onset of their diabetes. There was no apparent association between the age of the patient at onset of the illness, its duration, its severity, or the presence of vascular or neurological complications and the presence of impotence. Libido persisted for some time after the onset of impotence in most of the cases studied. The authors suggest that men complaining of premature impotence should be examined for possible diabetes mellitus.


A definite connection between diabetes and problems with penile erection exists. This paper discusses impotence in diabetic patients in light of the clinical experience gathered in two diabetes treatment clinics. An unusually high incidence of impotence was found among 198 men attending these clinics. The author asserts that for many of the patients who become impotent, potency returns when the diabetes is controlled.


This chapter reports and discusses the results of histological examinations of testicular biopsies in diabetic patients with sexual dysfunctions. Results revealed hypospermatogenesys with partial arrest in the maturation of the germinal epithelium. Case histories and clinical findings in 160 sexually impotent diabetic patients are summarized and compared to those in 154 diabetics without sexual dysfunctions. The author asserts that research results “suggest that impotence and infertility in male diabetics are due to secondary hypogonadotropic hypogonadism.”

This paper presents data on sexual development, libido, potency, and fertility in a selected group of male diabetic outpatients (n=314). The authors also conducted extensive laboratory investigation of endocrine and testicular function in patients with clinical evidence of sexual disorder. Results of this investigation are presented and discussed.


This study examined the sexual functioning of 50 women with metastatic breast cancer who had undergone hypophysectomy as a therapeutic measure to check the progress of the disease. In the first stage of the study, 20 women were interviewed before and after hypophysectomy with regard to their sexual functioning and activity. In the second phase of the study, 30 women were studied after hypophysectomy. Of these women, 23 had previously undergone mastectomy. Results showed that mastectomy did not have a significant influence on the patients’ sexual functioning, whereas hypophysectomy resulted in a sharp decrease of sexual desire, activity, and gratification. The decline in sexual functioning was attributed to the absence of the tropic pituitary hormone which activates the adrenal androgens. Other results are discussed and conclusions are presented.


This thesis presents the results of a detailed clinical investigation of the sexual functioning of 216 male diabetics and 1,010 age-matched healthy controls. Subjects ranged from 20 to 55 years of age. Impotence was found to be 15 to 30 times more prevalent in diabetics than in the healthy controls. In the diabetic patients 20 to 35 years of age, 53.6 percent admitted to being impotent, and in the patients between 36 and 55 years of age, the incidence of impotence was 79 percent. Psychiatric histories and examinations taken from patients, and the fact that 60 percent of the impotent diabetics were experiencing morning erections, led the author to suggest that impotence in the majority of cases was psychologic and not organic in nature.

This study examined testicular histology in diabetic patients who were sexually impotent. Testicular biopsy was performed in 11 diabetic patients with normal sexual function, 25 diabetics who were sexually impotent, and 20 nondiabetic, healthy persons. Of 11 sexually functioning diabetics, 5 showed changes in testicular histology. Of the 25 impotent patients, 4 had no pathological changes and 7 showed complete atrophy. The remaining cases had variable degrees of basement membrane thickening, maturation arrest, atrophy of germinal epithelium, and relative preponderance of Sertoli cells. These changes were found more frequently in the diabetic patients than in controls. There was no significant correlation between impotence and histological findings.


In this editorial, Sprague presents his commentary on the findings of a study conducted by Schoffling and his associates regarding impotence in diabetic patients. The unusual extent of this study and the fact that some of its findings appear to be at variance with the observations of many physicians are discussed. Schoffling's study is described as “a provocative report of an extensive, ambitious study of the endocrinology of sexual disorders in male diabetics, involving complex technics of endocrine investigation.” One of this study’s striking findings was the successful therapeutic results obtained by testosterone therapy alone. This was contrary to the observation of many clinicians that testosterone has little therapeutic value in the treatment of impotence associated with diabetes. Schoffling’s study is presented in this issue of *Diabetes*.


The purpose of this study was to examine sexual functioning and activity in 29 women, mean age 51 years, following oophorectomy and adrenalectomy for metastatic breast cancer. Of the 17 patients reporting some sexual desire before operation, 16 experienced a de-
crease in sexual desire after surgery. Of the 17 patients sexually active preoperatively, all reduced their frequency of sexual activity postoperatively, almost half stopping entirely. The authors conclude that the adrenal glands and, more specifically, the androgens of adrenal origin play a critical part in maintaining the patterns of sexual behavior in women.


Physiological and medical aspects of retrograde ejaculation associated with diabetes are briefly discussed in this article.

***Renal Failure***

Abram, H. S., Hester, L. R., Epstein, G. M., and Sheridan, W. F.


The main purpose of this study was to examine the sexual histories of male patients with chronic renal failure and the effect of intermittent dialysis and renal transplantation on their sexual functioning (n = 32). Results are presented and discussed.

Abram, H. S., Hester, L. R., Sheridan, W. F., and Epstein, G. M.


This article discusses psychological and sexual function implications involved in chronic renal failure and its treatment. The researchers studied sexual functioning in 32 dialysis and transplant patients. For some subjects it was possible to obtain a profile of sexual activity prior to the onset of the disease, while on dialysis treatment, and after transplantation. The major indicator of sexual activity was the frequency of sexual intercourse. Results showed that approximately 20 percent of the patients reported no decreased sexual functioning at any point during the course of their illness and treatment; 45 percent showed de-
crease in sexual activity after the onset of chronic renal disease, and 35 percent had reduced potency after the beginning of dialysis treatment. Therefore, the institution of dialysis cannot be considered the main etiological factor in all patients with reduced sexual potency. In the group of patients with functioning homografts, 20 percent maintained their sexual functioning as before the onset of illness or while on dialysis, and 40 percent reported that they regained their sexual potency after experiencing reduced sexual activity after onset of the disease or while on dialysis. Another 40 percent did not regain potency. The authors encourage more in-depth and longitudinal studies in this area.


In this study, 18 married men on home dialysis and 10 of their wives were interviewed to evaluate sexual adjustment. Results regarding frequency of intercourse, libido, and other variables are presented.


An investigation of 35 patients on maintenance hemodialysis suggested that most of them enjoyed an active sex life.


Psychosexual aspects in hemodialysis patients are discussed in light of the nurse’s role in providing needed counseling.


Male patients with chronic renal failure undergoing maintenance hemodialysis were evaluated with regard to testicular function. The patients included two unmarried men, ages 19 and 23, and four married men, ages 30 to 54. The length of renal failure was six months to five years. Significant abnormalities in spermatogenesis were found in
all patients. However, one patient had exhibited potency only nine months before the onset of renal failure. It was tentatively concluded by the authors that the renal disease contributed to the spermatogenic disorder.


Psychosocial aspects in hemodialysis patients are identified and discussed in light of recent literature and clinical observation. Topics covered are the stages of adaptation to hemodialysis, psychological defense mechanisms employed by patients, personality structures and special psychological problems of patients, depression, suicidal behavior, and marital and sexual problems. The author reviews findings of previous studies examining sexual functioning in hemodialysis patients. He suggests that problems of potency may be related to the "impact of the reversal of family role upon the tenuous masculine identity of these patients." It was noted that seven of eleven male patients studied were masturbating openly during the process of hemodialysis. The author attributed this primarily to a manifestation of anxiety from the stress of hemodialysis. It is the author's general impression that female patients as a group manifest fewer difficulties in sexual functioning.


This paper evaluates sexual functioning of 56 male kidney transplant recipients and 287 males who were on hemodialysis without transplantation. These subjects responded to a questionnaire mailed to transplant and dialysis patients in a nationwide survey. In the transplant patients, sexual functioning prior to uremia was compared with that after transplantation only, without a comparison to sexual activity in the same group while on dialysis. It was concluded that sexual functioning was markedly reduced following transplantation. However, 72 percent of those who replied to the questionnaire did report having intercourse after transplantation, while 26 percent reported a minimum frequency of two times per week. Of the hemodialysis patients, 10 percent reported absence of sexual intercourse prior to illness, compared with 50 percent while on dialysis. The author concludes that emotional factors play a role in the cause of sexual dysfunction among hemodialysis patients. Sexual problems which did not diminish with the improvement of physical conditions seemed to support this hypothesis.

Eighteen hemodialysis patients were interviewed in an attempt to rate their quality of life. Sexual functioning was one of the variables studied.


The special needs of dialysis and transplant patients for sexual counseling, and the role of health-care professionals in meeting these needs, are discussed.


The author discusses psychosocial and sexual aspects of dialysis patients. Recent advances in the treatment of severe renal disease have greatly improved the patient's chances for survival. However, despite these advances, the renal patient undergoing dialysis is subject to physical, psychological, social, and sexual stresses. Psychophysical stresses include fear of disability, fear of death, depression, and loss of self-esteem. Social stresses include job loss and financial difficulties. Very few studies have been done regarding the sexual stresses of the renal patient. Generally the studies of males have found a decrease in frequency of intercourse from pre-uremia to the uremic phase, and a further decrease from the uremic phase to the dialysis phase. Health-care workers must deal with the psychosexual difficulties of the patient in an attempt to alleviate these problems.


The purpose of this study was to examine changes in sexual function after renal transplantation. Subjects were 130 male patients between the ages of 20 and 60 who have received kidney transplants. The average follow-up period on subjects after transplantation was 36 months. Subjects were given a questionnaire specifically developed for this study to assess changes in level of libido and sexual potency. Results show a marked decrease in frequency of successful sexual coitus in patients with end-stage renal failure. After a kidney transplant, most patients reported a return to a pre-illness level of sexual functioning. Fourteen percent of the subjects reported that they had no sexual inter-
course prior to illness, compared with 47 percent during end-stage renal failure and 22 percent after kidney transplantation. The authors concluded that “this study indicates that the majority of men with functioning kidneys can look forward to a return of sexual activity comparable to the pre-illness state.”


Fourteen patients with chronic renal failure and on a hemodialysis program underwent neurologic, psychiatric, and endocrine studies to determine the frequency and etiology of impotence among them. Results are presented and discussed.


The ability to maintain sexual adequacy is one concern of patients with renal disease. In this brief guide to office counseling, the author outlines and discusses the effects of renal disease on sexual functioning in both hemodialysis and renal transplantation patients. Specific suggestions for counseling are also presented.


This study evaluated the sexual functioning of 22 male patients undergoing chronic hemodialysis for longer than six months. Of these patients, 46 percent maintained some sexual function. Sexual activity was more apparent among the home dialysis patients. Generally, loss of desire for sexual activity appeared to be more prevalent than loss of potency. The author concludes that “patients on chronic hemodialysis may produce a model for the etiology and treatment of organic impotence.”

The purpose of this study was to investigate the anatomic and histologic alterations in the vagina and its surrounding structures following irradiation. The report presented in this article is based on a study of 97 cases of invasive carcinoma of the uterine cervix. Features frequently present in radiotherapy patients were narrowing or obliteration of the vagina, pelvic fibrosis, and pain or discomfort on pelvic examination. No specific sexual dysfunctions are described.


The authors, motivated by the lack of research on the sexual function of women following therapy for cervical carcinoma, conducted this major study. The main purpose of the study was to examine the effect of different therapeutic approaches for invasive carcinoma of the cervix on the sexual function of patients (n=97). Three modes of therapy were used: radiotherapy alone, surgery alone, and a combination of both. Frequency of sexual intercourse was the major criterion for assessing sexual function or dysfunction in the subjects. That is, only when there was a decrease in the frequency of sexual intercourse were there also other sexual dysfunctions in patients, such as painful intercourse, lack of libido, etc. Results showed that shortening of the vagina interfered markedly with the sexual function of most of the women treated with radiotherapy, while only 2 of 32 surgically treated patients reported sexual dysfunction. The authors therefore give preference to radical surgery in the management of early carcinoma of the cervix. It was also found that the percentage of patients having anatomical distortions and sexual dysfunctions was similar in the three groups regardless of treatment mode.

This paper presents the results of a study examining urinary disturbance and sexual difficulties in patients following rectal cancer. An evaluation of a new method of pudential nerve block as a countermeasure for vesical disturbance is also given. Subjects were 296 patients who had radical surgery for cancer. Results show that 96 percent of 101 patients less than 60 years of age reported being sexually active before surgery. Postoperatively, however, 4.2 percent reported accelerated sexual functioning, 15.2 percent maintained usual functioning, 43.1 percent reported reduced sexual activity, and 37.5 percent abstained completely. Of the patients over 60 years of age, 41.4 percent reported reduced sexual function following surgery, and 51.7 percent abstained. Other results are discussed.


The author discusses the effects of surgical operations for cancer of the sigmoid colon and rectum on sexual functioning of male patients. Detailed descriptions of the anatomy and physiology of both erection and ejaculation are presented, with specific implications of possible dysfunctions in the patient following radical surgery for cancer of the rectum and colon. Possibilities for preserving sexual functioning in such patients are also discussed. Reports of the incidence of sexual impotence in these patients vary from 53 to 100 percent, with an average reported incidence of 76 percent. When surgery carries with it possible sexual complications, "the surgeon should be prepared to intelligently and tactfully discuss the subject with the patient and to counsel him in the event that dysfunction or impotence does occur." Several forms of noncoital sexual techniques are still available for the patient who loses sexual potency.


Many questions and concerns enter the mind of the new ostomate regarding social interaction, sexual functioning, and marriage prospects. This booklet discusses these and other areas of interest such as sexual incapacities, sexual techniques, birth control, and homosexuality.

Brown, R. S. Sexual life of women following pelvic exenteration. In D. W. Abse, E. M. Nash, and L. M. R. Louden (Eds.),
Marital and sexual counseling in medical practice (2nd ed.).

The author presents the results of a study he conducted with 15 female patients following pelvic exenteration. The purpose of the study was to assess in these patients (1) social adjustment following the operation; (2) psychological adjustment to mutilation, especially the desexualization and the loss of bowel control following colostomy; (3) correlation of personality factors and the course of malignancy; and (4) the role of psychiatric support in treating the responses of these patients. The author, from his data, concluded that "despite the stresses to which these patients were subjected, overall social and psychological adjustment was favorable." Autoerotic practice and sexual dreams were reported by some women after the operation took place.


This is an abstract of a paper presented by the authors at the British Society of Gastroenterology. The purpose of the study presented was to examine sexual functioning and the nature of sexual problems experienced by ileostomy patients. Results and conclusions were reported.


The author asserts that following mastectomy the patient needs counseling in three major areas regarding her sexuality: (1) her image to the world; (2) her image to her mate; and (3) her sexual self-image. These three areas are discussed in relation to sexual adjustment, and specific guidelines for office counseling by a physician are presented.


The psychosexual impact of various surgical procedures in women is discussed. Specific procedures described include bilateral oophorectomy, hysterectomy, colpocleisis, radical pelvic operations, and other forms of surgery.

The emotional, sexual, and conception implications of various operative procedures performed on the pelvic and reproductive organs of women are identified and discussed. These include the psychological and sexual impact of castrating and sterilizing procedures, bilateral oophorectomy, hysterectomy, vaginal procedures, obstetrical operations, and radical pelvic operative procedures. The author concludes by suggesting that "proper preoperative evaluation for any pelvic surgery should be comprehensive, dealing with fantasies and expectations, so that the resulting emotional response will be positive. In this way the postoperative recovery of women will be enhanced."


Psychosexual problems associated with ileostomy or colostomy are discussed in light of research and clinical findings. Also presented are data obtained by the authors from 500 questionnaires and personal interviews with patients in psychotherapy. Questions were patterned on those of Kinsey, covering various aspects of the patients' sexual activities, attitudes, and adjustments.


In an attempt to dispel myths and taboos surrounding colostomy and ileostomy, the authors conducted this study to examine the psychosexual implications and adjustment following these operations. A questionnaire survey was conducted among 500 members of various ostomy associations. Results show that potency and fertility do suffer somewhat, but not to the extent and degree previous estimates would indicate. The importance of counseling and the role of the physician in facilitating the patients' psychosexual adjustment are stressed and discussed.


The underlying message of this report is that when sexual dysfunctions occur in postoperative hysterectomy patients it is mostly a result of psychosocial factors and not of the physical condition per se. The major factor is related to irrational fears and the psychological effects of surgery in the female genital area. Other intervening aspects may include preoperative regret for the loss of childbearing ability; ambivalence about loss of menstruation; fear of the effects of surgery.
on everyday feminine activities and roles; fear of sexual unaccept-
ability to spouse or partner; actual postoperative side-effects of hy-
sterectomy that indirectly affect sexuality, e.g., bowel irregularities, 
loss of appetite, weight gain, feelings of weakness, fragility, and vul-
nerability; and the belief that hysterectomy was a punishment for sex-
ual sins. The author concludes that “the physician is best equipped to 
handle these sexual problems when he clearly recognizes that hysterecto-
my and the surgical menopause in mature females need not, in them-
selves, cause a decrease in sexual desire, sexual pleasure, or ability to 
participate in sex.”

Drellich, M. G., and Bieber, I. The psychologic importance of the 
uterus and its functions: Some psychoanalytic implications of 
hysterectomy. Journal of Nervous and Mental Disease, 1958, 
126, 322–336.

This paper presents the findings of a series of psychological observa-
tions made on randomly selected premenopausal women who had 
undergone hysterectomies (n=23). The purpose of the study was to 
determine the importance of the possession of the uterus in female 
adaptation. Most subjects viewed the uterus as a sexual organ, child-
bearing organ, reservoir of strength, and maintainer of youth and 
attractiveness. Surgery was sometimes viewed as punishment for guilt-
laden attitudes involving sexual activities. The authors suggest that “the 
uterus is regarded by many women as an important symbol of feminin-
ity, onto which is projected attitudes towards sexual and nonsexual 
female functions.” Most of the subjects expressed some anxiety con-
cerning their ability to participate in sexual relations, the possibility 
of sexual rejection by husbands, the loss of sexual attractiveness, and 
their ability to satisfy their husbands sexually.

Druss, R., O’Connor, J., and Stern, W. Changes in body image 
following ileostomy. Psychoanalytic Quarterly, 1972, 41, 195– 
207.

The case histories of four women who had permanent ileostomy 
after total colectomy for ulcerative colitis are studied and discussed. 
Five phenomena were observed in these four women: (1) Phantom 
rectum: For a couple of weeks after the surgery they had a sense of 
fullness and an urge toward bowel movement. The rectum, of course, 
did not exist, so this was perhaps the patient’s denial of the loss of a 
body part through surgery. (2) The stoma as phallus: While many
patients felt a loss of a major organ, the bowel, these four women reacted as if they had a gain. To them the stoma looked like a penis. (3) Exhibitionism: All four women were happy to disrobe for medical personnel in mixed audiences. (4) Erotic feelings toward the surgeon: These women felt conscious excitement sexually for their surgeons. (5) Changes in personality and life style: Denial and hypomania were used as defense mechanisms against depression and anxiety about bodily mutilation. Also noticed was an actively directed aggressive behavior.


Intensive interviews were conducted with 29 men and 28 women to determine the psychosocial impact of abdominoperineal resection with establishment of a dry colostomy. The focus of these interviews was on the adaptation of the spouse and other family members to the colostomy patient. Adaptation was examined in the areas of work, sexual functioning and activity, and social life. Results and conclusions of this extensive study are presented.


Emotional reactions to and psychosocial and sexual problems associated with mastectomy are discussed in this article.


The effect of prostatectomy on the patient’s sexual function, and suggestions for treatment and sexual counseling are discussed. The majority of more than 200 aging men examined, who were sexually active prior to operation, retained their sexual function post-operatively.


This article presents and discusses the results of a study aimed at examining sexual functioning in patients following perineal prostatectomy (n=26). Results revealed that there was preservation of sexual potency in about 70 percent of the patients. Age, per se, was not found
to be a limiting factor in maintaining sexual potency. The author concludes that “sexual impotency is no more common following perineal prostatectomy than other surgical approaches to the gland.”


This booklet was written for both the male ostomate and his sexual partner in order to assist them in achieving a psychological adjustment to sex with an ostomy and to provide advice for the management of the ostomy for a satisfying sex life. Information was gathered from various sources, including a survey of 95 male ostomates who answered a lengthy questionnaire which covered a wide range of aspects of their sexual functioning. There are four major sections in this publication: (1) the anatomy of ostomy, i.e., ileostomy, urostomy, and colostomy; (2) psychological problems following surgery, i.e., fear of failure in sexual functioning; (3) making love, including ostomy management, sexual positions, overcoming sexual difficulties; and (4) organic problems following surgery, including impotence, orgasmic dysfunctions, ejaculatory incompetence, and sterility.


The purpose of this study was to examine the status of sexual potency in men one year following prostate surgery. Ninety-four individuals, from 41 to 82 years of age, were studied. A control group of 34 aging men who had undergone inguinal herniorrhaphy one year before the study was also included. The results show that 80 percent of the patients in the youngest age group (50 to 60 years) reported no change in sexual potency following prostatectomy, compared to only 32 to 34 percent of the patients in the two older groups (61 to 80 years). No significant relation was found between the type of prostatectomy undergone and resulting impotency. Of the entire group, 81 percent reported the presence of retrograde ejaculation. In the control group it was found that 97 percent of the men reported no change in sexual potency, which excludes lower abdominal surgery per se as a contributing factor to prostatectomy impotency. In conclusion, it appears that the age of an individual undergoing a prostatectomy is a very significant factor in determining how his sexual potency will be affected. In addition, it appears that a great proportion of the men who have undergone a prostatectomy experience a sizable reduction in sexual performance.

This article presents and discusses the results of a study aimed at the examination of sexual functioning in male patients following excision of the rectum (n=95). The author reports that penile erections occurred in 72 percent of the patients, and that sexual intercourse was successful in 64 percent of those. All patients who had intercourse experienced orgasm, but 39 percent had retrograde ejaculation. This condition results from failure of the vesical neck to close during orgasm.


The author notes that “organic sexual impotence in the male patient is virtually an inevitable consequence of radical cystectomy or radical prostatectomy.” This article presents case reports of two patients who underwent radical cystectomy and whose resulting impotence was successfully managed by the insertion of a silicone plastic prosthesis. Based on these experiences the author concludes that impotence resulting from radical cystectomy can be successfully managed by this surgical procedure in carefully selected patients who are mentally stable, relatively young, and free of diseases two or more years after surgery.


The treatment of metastatic breast cancer, with an emphasis on testosterone treatment, and its effect on sexual functioning and behavior is the main subject discussed in this article.


The paper examines the impact of cancer on marital, sexual, and family relationships, and its similarities to other traumatic events, such as loss of a loved one, divorce, or loss of a job. Case histories of six patients are presented to illustrate the psychosocial and sexual aspects of cancer.


Following a review of relevant literature, the author concludes that the evidence suggests that hysterectomy often sets off profound psycho-
logical problems in postoperative patients. He adds: "it is my contention that the operation is perceived as a blow to femininity by almost all women." The author presents four detailed case studies of hysterectomy patients and discusses the psychosocial and sexual difficulties and problems faced by these women. Reassuring the patient about her femininity can be supportive and helpful. The gynecologist needs to provide accurate information and encouragement by informing the patient that the removal of the uterus does not mean the end of her sexual life or feminine attractiveness.


Psychosexual difficulties and specific steps in counseling the patient who is to undergo a hysterectomy are discussed in this brief guide to office counseling.


Ileostomy or colostomy can result in some sexual difficulties for the patient. This brief paper discusses these difficulties and presents suggestions for counseling to be provided by the physician. A thorough sex history and physical examination, coupled with indicated laboratory procedures, are essential to counseling the patient regarding sexuality. The psychological impact of the stoma, interpersonal relationship problems faced by the patient, and the mechanics of sexual activities following ileostomy or colostomy are also discussed. The physician is encouraged to make referrals to a sex therapist when needed.


According to the author, cystectomy always results in significant sexual dysfunction in the male patient and frequently in the female patient. After cystectomy, a man is unable to obtain an erection, and seminal emission and ejaculation are absent. Sex counseling and penile prostheses for these patients are two additional topics discussed.


Written to answer some of the questions and alleviate apprehensions that the female ostomate might have concerning her sexual attractive-
ness or her ability to handle the problems of pregnancy and birth, this article was compiled from responses made by ostomate mothers to a questionnaire survey carried out by the United Ostomy Association. These responses indicated that ostomies present no untoward problems in themselves and that courting, romance, sex, and pregnancy can and do proceed normally for most ostomates. Practical suggestions are made for adjustments to the stoma or the appliance that might be necessary during sexual activity and during pregnancy, with explanatory quotations from doctors and ostomates.


Aimed primarily at the female ostomate, this booklet discusses various physical, psychological, social, and sexual implications of ostomy for both the patient and her spouse. Sexual functioning, pregnancy, diet, and delivery in these patients are also covered.


The purpose of this study was to identify behavioral characteristics associated with contracting cervical cancer. A group of fifty women with the malignancy and an equal number of controls were compared in terms of past and present sexual behavior and hygiene practice. The study group was found to display higher rates of venereal diseases, less douching after intercourse, less use of contraceptives such as jellies and foams, greater use of Lysol solution as a first douche, and more births outside a medical setting than in the control group. This finding suggests that cervical cancer could be related to some unknown agent which might be transmitted through sexual activities.


The authors report selected early data from a large multivariate study they conducted in an attempt to investigate components possibly associated with the onset and incidence of cervical cancer. The selected psychological and sexual variables in this article were studied for interrelationships and for differences between patients and controls. It was found that there was no clearly significant difference between patients and controls in general affect toward sexual intercourse as determined
from responses to the question "what do you think about during the act of sexual intercourse?" Sexual affect scores were found to be related positively to presence or absence of orgasm, frequency of orgasm, and presence or absence of masturbation.


Thirty-two female patients with carcinoma of the breast who had had radical mastectomies were studied in order to examine the effects of sex hormone therapy on sexual behavior and functioning. Results led the authors to conclude that 1) androgens heighten sexual desire in breast cancer patients, whereas estrogens do not; 2) the types of changes brought about by sex hormone treatment can sometimes be traceable to earlier patterns of the person’s sexual adjustment; and 3) the less sexually inhibited patients were more strongly affected by the androgens, the more sexually inhibited women were either less affected or not affected at all by this treatment.


Unusually great sexual drive, multiple partners, and history of venereal disease appear to be related to prostatic cancer. These and other sexual aspects of this disease are discussed. Also presented are the results of a study conducted by the author to examine patterns of sexual behavior exhibited by prostatic cancer patients.


The purpose of this study was to evaluate the psychologic, sexual, and physical well-being of a group of postradiation patients treated for cervical carcinoma (n=16). The patients’ case histories, results, and recommendations for evaluation and treatment of this disease are presented.


Data concerning sexual behavior were obtained from a group of women following oophorectomy and adrenalectomy for metastatic cancer of the breast. Vaginal smears from most of the patients were also available. Decreased cytological activity in the vaginal mucosa and decreased sexual desire, activity, and responsiveness were found in these patients. Other findings are analyzed and discussed.


The purpose of this article was to examine the psychosexual impact of various modes of therapy utilized in the treatment of gynecic malignancy. It emphasizes the necessity for sensitivity on the part of physicians so as to avoid postoperative sexual dysfunction in patients. The methods of treatment and therapy differ with the various types of lesions and the extent of the disease at the time of surgery. In general, early lesions are treated surgically with less posttherapy dysfunction. This reduces the chances of vaginal stenosis and atrophy. The earlier the surgery, the better the prognosis for continued normal coital function. In cases of more radical surgery, radiotherapy is often necessary. These treatments can often be severely destructive to coital function. There is a possibility that this can be avoided with intensive posttherapy care and counseling. The physician must be aware of the fears and anxieties suffered by patients with a malignant disease. With proper care, education, and counseling, almost all sexual dysfunctions can be avoided.


According to the author, the emotional trauma of mastectomy is greater than the physical trauma. More should be done to prepare the patient and her spouse to work together toward a resolution of the crisis. This article is an effort in that direction, aimed primarily at sex therapists. The therapist is encouraged to help both the patient and her partner to confront the mastectomy experience. Intercourse should occur as soon as possible following surgery. The husband should be as compassionate, supportive, and expressive of his love and concern for his wife and her feelings as possible. All efforts should be directed at prevention of loss of self-esteem on the part of the patient. Certain sex
therapy exercises (body imagery and sensory focus) are described. Their aim is to promote acceptance of the loss and the sharing of the emotional experience between the sexual partners.


Mastectomy may have a negative effect on the woman's sex life if she believes the disfiguring surgery has left her sexually unacceptable or inadequate. The biologic, psychologic, and sociocultural factors affecting the postoperative sexual adjustment of the patient are outlined and discussed. Pain in the operation area, the patient's perception of her sex partner's reaction, and societal standards of sexual desirability are a few of the factors affecting the sexual adjustment of mastectomy patients. Also discussed is the practicing nurse's role and function in the sexual adjustment process of these patients. The nurse has to evaluate the patient's ability for adjustment and her need for counseling and advice in this area.

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**Obesity**


Allon conducted 200 open-ended interviews with female participants in group dieting meetings. The interviews focused on the relationships between overweight and sexual orientation. Four major themes about the relationship between overweight and sexuality were found: (1) 75 percent of the subjects made reference to sexual promiscuity in regard to their losing or not losing weight; (2) the next most common theme cited by subjects was labeled by the author as "feeling of sexiness." Some 55 percent of the sample made reference to their gaining or losing sexiness as a result of losing weight; (3) about 40 percent of the subjects reported a relationship between eating or food and sexuality. Most of these women stressed the idea of food as a substitute for sex-
ual activity; (4) 35 percent of the participating women showed signs of poor body image and its relationship to overweight and sexuality. Many women labeled themselves "ugly" and sexually "unattractive" because of their overweight.


Sexual conflicts and difficulties resulting from and associated with overweight and obesity are discussed.


Weight increase may be a response to sexual frustration or may be a defense against sexuality. This and other relationships between obesity and emotional and psychosexual problems are discussed in this article. Therapeutic management of those obese persons with difficulties demands evaluation of the individual circumstances.


The author identifies and discusses the psychosexual implications of obesity in women. Negative self-image, fear of competition with other, more attractive women, and the adjustment to changed body image are some of the problem areas covered. Some specific suggestions for counseling are also presented.


Psychological, social, and sexual difficulties and problems associated with obesity and weight control are discussed in light of a comprehensive review of the literature.


Of particular interest in this book is a chapter discussing the association between obesity and sexuality, and various techniques of sexual coitus for obese couples.


The association between obesity and sexuality, the impact of obesity on sexual functioning, and sexual stimulation techniques for obese couples are some of the topics discussed in this book. Numerous case
histories from the author's clinical practice are presented for illustration.


Long-standing obesity was treated in a 34-year-old woman by means of surgical bypass of the small bowel. This paper presents and discusses this woman's case report, emphasizing her sexuality after undergoing such a procedure.


The author asserts that “a patient preoccupation with eating, dieting and weight control may be symptomatic of psychopathologic condition, the appreciation of which aids the family physician in his diagnosis and management and alerts him to those situations in which a psychiatric consultation may be indicated.” Reflecting upon his clinical experience and a thorough review of relevant literature, the author outlines and discusses the psychological and sexual aspects of eating and weight problems and the specific medical disorders that may accompany them. Several case reports are presented and analyzed to illustrate these relationships. One of the cases involved a depressed 23-year-old woman whose conflicts were related to orality, sexuality, and dependence-independence. The patient was denying her husband sex, and finding “self-gratification in the bizarre ritual of eating and vomiting.”