

## TREATMENT OF 26 CASES OF MALE SEXUAL DYSFUNCTION BY BEHAVIOUR MODIFICATION TECHNIQUES

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### SUMMARY

26 married males with premature ejaculation and secondary impotence were subjected to behaviour therapy. Relaxation, graded tasks, sensus exercise, the squeeze technique, desensitization and thought stopping were the techniques employed. 15 (58%) of the patients improved. Factors contributing to success or failure are studied and the results compared with those of others using Behaviour Therapy.

Behaviour therapy as advocated by Wolpe (1973) and other directive techniques introduced by Masters and Johnson (1970) are now being widely used in the treatment of male sexual dysfunctions. In our country, Venkoba Rao (1968), Agarwal (1975) and Kuruvilla (1975) have reported on the use of these techniques with male sexual problems. The present paper is a report of treatment by these methods of 26 married males suffering from premature ejaculation and secondary impotence.

### MATERIAL AND METHODS

The sample consisted of 26 married male patients with premature ejaculation or impotence but without depression, schizophrenia or alcoholism. Physical examination and relevant physical and psychological investigations were carried out before taking the patients on for treatment. For the purpose of this study a patient was considered to be a premature ejaculation if he could not control his ejaculatory process in more than 50% of coital connections, sexual potency being normal (Masters and Johnson 1970,

Leigh *et al.*, 1977) 11 patients belonged to this category.

The 15 cases of impotence had achieved successful intromissions in the past and were therefore labelled secondary. In all these 15 patients the stage of impotence was preceded by a stage of premature ejaculation.

The age range of our sample was between 20 and 40 years. The mean age was 29.9 years. Monthly income ranged from Rs. 500/- to Rs. 2000/-. 13 of the 26 patients had primary school education, the rest had attended secondary school and college.

As lack of information on normal sex has been shown to be contributory to sexual problems (Bagadia *et al.*, 1972, Weiss and English 1957, Allen 1969), the first two treatment sessions were devoted to education of the patient and spouse covering the following aspects.

1. Basic anatomy and physiology of the male and female reproductive systems using Clay models and charts.
2. Fear, Anger and other strong emotions, overt or repressed, can hamper proper sexual functioning.

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3. It may be difficult to have an erection at will and in an uncondusive atmosphere.
4. Coitus and seminal discharge have devitalizing effects and do not lead to or aggravate physical illnesses.

Free discussion was promoted and related issues raised by the patient were clarified.

Behaviour therapy consisted of the following techniques (Wolpe, 1973; Kaplan, 1974; Masters and Johnson, 1970).

1. Systematic desensitization to progressive stages of sexual interaction e. g. patient imagined while relaxed that he was approaching his spouse with an erection.
2. Thought stopping e. g. Distressing thoughts about past coital failures were induced and repeatedly stopped under relaxation.
3. Graded tasks.
  - a) Coitus was forbidden till satisfactory control over ejaculation was regained.
  - b) Stimulation by spouse and self till erection was achieved, then relaxation and maintenance of erection. Stimulation began again when erection weakened and stopped on threatened ejaculation. (a la Semans)
  - c) Spouse instructed to stop ejaculation by applying the "squeeze" to the penis (Masters & Johnson, 1970).
4. Coital position : The lateral coital and female superior positions were recommended to some for maintaining erections within the vagina. Normal coitus was permitted when the therapist assessed from the patient's self-reports that he was anxiety-free at all stages and could perform without risk of failure.

Satisfactory sexual functioning was said to be restored when the patient reported being anxiety-free at all stages

of intercourse, could maintain intravaginal movements for a sufficient duration of time and could ejaculate intravaginally at every sexual contact. Patient's self-report of satisfaction in sexual activity was our criterion for treatment success. Those reporting dissatisfaction in sexual life, and partial improvement only were considered as treatment-failures.

## RESULTS AND DISCUSSION

Satisfactory sexual functioning was restored in 15 (58%) of 26 patients undergoing adequate treatment by behaviour therapy. 11 (42%) failed to improve. 7 out of 11 cases of premature ejaculation and 8 out of 15 cases of impotence showed satisfactory improvement. Thus both these conditions appear amenable to behaviour modification.

Age, education and economic status had no association with improvement in our sample, on statistical analysis.

## DURATION OF DISABILITY AND IMPROVEMENT

As seen in Table I there was no statistically significant difference between the various groups but in the group

TABLE I

Duration of illness	Im- proved	Not Im- proved	Total
Less than 6 months	5	2	7
From 6 months to 1 year.	4	2	6
Between 1 year and 2 years.	3	2	5
Between 2 years and 5 years.	1	5	6
Between 5 years and 10 years.	2	0	2
<b>Total</b>	<b>15</b>	<b>11</b>	<b>26</b>

suffering from the disability for 2-5 years the results were poor, a finding difficult to explain.

#### NUMBER OF BEHAVIOUR THERAPY SESSIONS AND IMPROVEMENT

On an average, patients received 9.6 sessions of behaviour therapy over a period of 4 weeks beginning with the first interview. Each session lasted about 40 minutes. Two patients made rapid progress and improved totally in 5 sessions. We advocate a minimum of 10 sessions of behaviour modification for these two conditions, as a routine.

#### DURATION OF MARRIAGE, MARITAL DISHARMONY AND IMPROVEMENT

The duration of marriage was not correlated with outcome with behaviour therapy. Mean duration of marriage was 6.04 years. In those with a shorter duration of marriage performance anxiety and faulty concepts about sex were contributory to the sexual dysfunction. In those with a longer married life, marital disharmony was contributory to the illness.

Only 11 of the 26 married males could get their wives to co-operate for an interview at the behaviour therapy clinic. Improvement occurred in spite of the spouse not being interviewed (See Table II). The patients were able to carry out the behaviour therapy instructions

TABLE II

	Im- proved	Not im- proved	Total
1. Wife interviewed	3	8	11
2. Wife not interviewed.	12	3	15
Total	15	11	26

at home with their wife's assistance, though shyness prevented these spouses from visiting the clinic. There was no correlation between marital disharmony and not being able to bring the wife to the clinic. Since patients with marital disharmony accounted for more failures (See Table III), counselling or psychotherapy combined with behaviour therapy would seem necessary to restore adequate sexual functioning in such cases.

TABLE III.

	Im- proved	Not im- proved	Total
1. Marital disharmony.	5	6	11
2. No marital disharmony.	10	5	15
Total	15	11	26

Our success rate was 58%. Wolpe (1973) cured 14 out of 18 cases in 8 weeks. Masters and Johnson (1970) had a failure rate of only 2.2% with premature ejaculation and 26.2% with secondary impotence. Wright, Perreault and Mathieu (1977) in a review of treatments for sexual dysfunction conclude that behaviour therapy and directive sex techniques have produced better results than psychotherapy or psychoanalysis.

Kuruvilla's (1975) report of good improvement in 14 (54%) of 26 cases and Venkoba Rao's (1968) report of good improvement in 12 (60%) of 20 cases are comparable with our success rate of 58%.

Agarwal's (1975) high-drop-out rate and various sub-classifications make comparison difficult but his success rate is encouraging to those using behaviour therapy. In our study in contrast to the previous efforts, we seem to have

established that behaviour therapy can yield good results in spite of wife not being brought for interview. Even in preference of marital disharmony, in a few cases, by giving indirect instructions to wife through the patient, success in treatment can be achieved. This innovation seems essential for the treatment of sexual dysfunctions in our cultural milieu.

Our results fall short of the reports from abroad, and certain factors which contributed significantly to this are as follows :

1. Shy, orthodox spouse, uncooperative for behaviour therapy.
2. Non-compliance with instructions to abstain from intercourse.
3. Expectation of physical treatments being dispensed, which could not be fulfilled.
4. Difficulty in undergoing behaviour therapy because of—
  - a) Concealment of disability from wife by sending her to native place, feigning illness, undertaking austerities etc. and
  - b) lack of adequate accommodation in the city.

In view of the limited cooperation available from the couple, the lack of the necessary privacy for carrying out the behaviour therapy instructions and with the prevailing social taboos against sex, 58% success appears encouraging.

#### CASE ILLUSTRATIONS

**Case A :** Mr. D., aged 30, bank employee, married since 3 years, came with premature ejaculation since 1 1/2 years. Conflicts with wife and parents-in-law were contributory to performance anxiety, about which Mr. D. was briefed in session 1, day 1, in which basic sex education was also given. In session 2 patient was taught deep muscular relaxation and thought stopping. He provoked thoughts about failure in intercourse while relaxed and learnt to

stop them suddenly by saying "stop" mentally. Mr. D. practiced relaxation and thought-stopping twice daily for 15-20 minutes at home. From session 4, day 8, patient imagined while relaxed that he was approaching his wife for foreplay and subsequent stages of intercourse in a calm and relaxed manner.

Wife, though well-educated, declined to come to the clinic, but cooperated in carrying out instructions. From day 15, session 7 patient started sleeping with wife and attempted to maintain erection as long as possible by mutual stimulation. Wife was able to stop ejaculation by squeezing behind the glans penis about 50% of the time when ejaculation appeared imminent. These exercises were practiced at home about thrice daily. On day 20, session 9, patient reported that both he and wife were satisfied with the strength and duration of the erection and therefore intercourse was permitted. The sexual difficulty disappeared and did not recur for over 4 months, although at follow-up marital disharmony still persisted.

**Case B :** Patient A. M. aged 45, came with total impotence since 1 year, preceded by premature ejaculation for a period of 2 years. Treatment followed same pattern as in case A. After session 6 of relaxation with imagination of foreplay and coital scenes patient reported spontaneous erection during relaxation. From session 7, wife was involved in exciting the patient sexually and applying squeeze to the penis when ejaculation appeared imperative. From session 10, day 27, patient was asked to relax with the erect penis in the vagina in the lateral coital position. All exercises were carried out at home daily. Patient attempted intercourse and discharged prematurely once but morale was high and from day 37, patient reported mutually satisfactory intercourse.

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