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# Behavioural Intervention in the Management of Male Sexual Dysfunction

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## Abstract

The present study is an attempt to match varied behavioural strategies to individual cases of male sexual dysfunction and to assess the clinical significance of such interventions in the Indian set-up. Five clients completed the therapy programme. There of the clients treated had male erectile disorder and two had premature ejaculation with secondary impotence. Pre-therapy assessment was done after twelve sessions and post-therapy assessment after twenty five sessions. For assessment, behavioural analysis, Max Hamilton's anxiety and depression rating scales and Mishra's daily impotence rating scale were used. After assessment, based upon the behavioural formulation a therapeutic package comprising of Jacobson's progressive muscular relaxation, Masters and Johnson's technique, behavioural counselling and sex education was applied. The procedures were based on anxiety reduction, positive feed back and operant conditioning principles. Results were analysed using the client and his wife's report regarding sexual satisfaction and level of erection. Objective assessment of changes in associated anxiety and depression were analysed. The findings indicate that the behavioural package developed is efficacious for these clients. The clients reported greater sexual and marital satisfaction and improvement in strength and quality of erection.

Key words -
**Male erectile disorder,**
**Premature ejaculation,**
**Masters and Johnson's technique**

For most men in most societies sexual adequacy is considered a yardstick for measuring personal adequacy. The man who does not measure up sexually is often embarrassed, confused or depressed over his plight. The sexually dysfunction male may change his behaviour to avoid sexual situations, he may cope with this dilemma by inventing excuses or he may try to overcome his problem by diligently working at sex which usually makes the situation worse instead of better.

Erectile dysfunction or impotence is the inability to have or maintain an erection [1]. Premature ejaculation is the inability to control the ejaculatory process for a sufficient length of time during intra-vaginal containment to satisfy one's partner in at least fifty per cent of their coital connections. Various treatment approaches like hypno-therapy, group therapy, organic treatment methods and behavioural techniques have been attempted with cases of sexual dysfunction.

The present study is an effort to match varied behavioural strategies to individual cases of male sexual dysfunction and to assess the clinical significance of such intervention in the Indian set-up.

## Materials and Methods

### Sample:

Sample was drawn for NIMHANS/General Hospitals and private practitioners. Five clients completed the programme and three dropped out after initial interview. The clients were married between twenty-five to forty-five years and had either erectile disorder or premature ejaculation (DSM-3-R, 302.75 and DSM-3-R, 302.72). The duration of disorder was not less than six months. Organic causation, presence of gross psychotic features were ruled out.

### Design:

Sinle case study with multiple baseline assessments was used.

### Tools

The tools used were
(i) Clinical interview
(ii) Hamilton's depression rating scale [2].
(iii) Hamilton's anxiety rating scale [3].
(iv) Mishra's sexual impotence rating scale [4].
(v) Behavioural analysis.

Based upon the behavioural formulation a therapeutic package comprising of techniques selected from the following was applied in each case.
(i) Jacobson's progressive Muscular relaxation.
(ii) Masters and Johnson's technique.
(iii) Sex education.
(iv) Behavioural Counselling.

Each client attended twentyfive hours of therapy on the average excluding the pre and post assessment. One client attended five sessions. Each session lasted for one hour on the average. The first twelve sessions were conducted after pre-therapy assessment after which mid-therapy assessment was done. Following another thirteen sessions post assessment was done.

## Results

Every individual case was analysed in accordance with the data obtained from different stages of therapy in relation to the parameters of sexual dysfunctions, anxiety, depression, sexual knowledge, attitudes and sexual satisfaction.

### Case-I

Behavioural analysis showed that arousing cues were not being presented in sufficient strength to evoke arousal. They were getting masked almost entirely by concentration on performance cues. The

emotional reaction subsequent to partial erection was anxiety supported by negative self statements which were again inhibiting arousal and producing sadness.

A combination of sex education, Masters and Johnson's technique and behavioural counselling was adopted for this client.

The client reported hundred per cent erection at termination (on the daily impotence rating scale) and greater sexual arousal. The couple reported greater sexual and marital satisfaction. There was a marked reduction in both associated anxiety and depression.

### Case-II:

Traumatic extra-marital sexual experiences one and half years back led to conditioned anxiety in sexual situation. Guilt over masturbation, extra-marital affairs, mis-conceptions regarding the harmful effects of masturbation served to maintain the dysfunctional behaviour-importance.

A therapeutic package of self-education Masters and Johnson's technique and behavioural counselling was adopted for this couple. At the end of the therapy the client reported eighty per cent improvement in his overall sexual satisfaction. He reported getting an erection of ninety per cent strength and reduction in sadness and fearfulness. Wife too reported to experiencing orgasm and greater sexual satisfaction.

### Case-III:

Concentration on performance was interfering with potentially erotic stimuli. Arousing erotic cues were not being presented in sufficient intensity to evoke arousal. They were being masked by concentration on performance cues. Therapeutic package selected for this client included sex education, behavioural counselling and Masters and Johnson's technique. At termination client reported full erection. He reported greater levels of sexual arousal and greater sexual satisfaction. There was a marked decline in his associated anxiety and depressive features. Wife too reported satisfaction in their sexual encounters.

### Case-IV:

Stress associated with sexual cues via a classical conditioning process evoked anxiety. This anxiety interfered with the clients ability to control ejaculation. The therapeutic package adopted for this client included J P M R., sex education, behavioural counselling and Masters and Johnson's technique. Since the client's wife was already six months pregnant, the therapy programme had to be altered. The female superior position was not adopted. The client at termination reported greater sexual satisfaction. His level of sexual arousal was high and the erection increased to eighty per cent. There was marked decrease in his associated anxiety and depression.

### Case-V:

Performance anxiety was a conditioned emotional response following an upsetting sexual experience. As a result of erectile failure the client experienced humiliation, embarrassment and criticism. Anxiety was interfering with his ability to control ejaculation. The therapy package adopted for this client included sex education, behavioural counselling, and Masters and Johnson's technique. In this case, the couple decided to terminate the therapy after four sessions. After 15 days of termination, the couple reported greater sexual satisfaction. The client reported that he was getting full erection and that this ejaculatory control had improved markedly. He reported a decline in his nervousness and depression.

## Discussion

A total of twenty clients with male sexual dysfunctions were screened. Of these, six did not fit in to the inclusion-exclusion criteria and were therefore not considered. Out of the remaining fourteen, six clients opted out of the therapeutic programme after the initial clinical interview, and three dropped out of the programme after initial assessment and therapeutic work.

As can be seen from the Table I there are no distinct socio-demographic features that distinguish the therapy completers from the non-completers. The nine clients who opted out of the therapy did so for the following reasons:

***Table I - Socio-demographic variables and nature of dysfunctions among the therapy completers and non-completers***

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1. Expectations of drug management.
2. Unwillingness to involve the wife in the therapy programme.
3. Long distance travelling, and commuting problems.
4. Inability to get leave from the office for one month period.
5. Lack of adequate accommodation in the city.

The three clients who dropped out of the therapy programme in the initial phase did so because of

1. Shy orthodox wife who simply refused to co-operate and come for therapy at all after the first session.
2. After the initial couple of sessions, client felt that nothing new was being offered and was unconvinced that without drugs the problem could be managed. Client did not believe in the psychological etiology of the dysfunction.

The five clients who completed the therapy were mainly from lower or middle class strata. A common problem which many of them faced was lack of adequate privacy and sleeping spaces. All these clients had high motivations to get well, were found to be anxious and concerned about their dysfunction and were of average intelligence. None of these clients had any history of alcoholism, diabetes or organicity. In all five cases duration of illness was not more than one year. The results indicate that the behavioural package adopted has been successful in reducing the severity and the intensity of the dysfunctional behaviour. In four cases clients reported 90 to 100 per cent improvement and greater sexual satisfaction. In one case where the wife was pregnant, the entire package could not be applied. The client reported marked improvement at the time of termination.

A detailed assessment of the couples sexual attitudes and their awareness was done in the pre-therapy assessment phase. In all the five cases the wives were found to be grossly ignorant about sexual information and were invariably passive partners. None of the wives had experienced an orgasm and had looked at sex as something to be endured for their husband's sake. They were aware of the function of sex in reproduction but not of its pleasure aspects. Therefore an important aspect of the therapy package became sex education. The husbands were also taught the ways to facilitate orgasms for their wives. This helped to increase the sexual satisfaction in general. After the therapy the husbands reported the wives as being more enthusiastic about sex and taking more initiative as

compared to previous sexual functioning. In all five cases husbands were found to be poorly educated about sex and had several misconceptions which was hampering their sexual performance. These included

1. Regarding masturbation as sinful with harmful physical effects.
2. Guilt over masturbation.
3. Regarding masturbation as the cause of present sexual dysfunctioning.
4. Regarding sex to be secretive, shameful and yet pleasurable act. Considering semen discharge harmful, believing that small size of the penis affects performance.
5. Ignorance about the female menstrual cycle, being worried about white discharge.

Most of the clients were from conservative family backgrounds where sex was not discussed openly. Some of them had gone to tantriks and folk healers before coming for therapy. It is interesting to note that in the present sample none of the clients were aware of Dhat syndrome.

In case-V the client's problems were created entirely by misconceptions and misinformations regarding sex. Ninety per cent improvement was reported by the couple after four sessions of therapy in which behavioural counselling and sex education was done. An analysis of all five cases shows that maximum therapeutic gain achieved in the non-genital sensate focus. This could be due to the fact that previously the couples were engaging in minimal sexual foreplay and sex merely meant penile-vaginal penetration.

According to Callanham and Lietenberg [5], Masters and Johnson's sensate focus is akin to operant procedure of reinforced practice. In the sensate focus procedure, couples were instructed to create a non-demanding atmosphere and concentrate on pleasurable and rewarding sensations. Sexual skills training also turned out to be an effective tool in the management of dysfunctional behaviour. In all five cases cognitive restructuring played an important role in reducing the performance anxiety and helping the client to see that the failure to get an erection does not amount to failure in general. The clients were encouraged to make self supporting attributions as opposed to self depreciating ones.

For assessment purpose, daily impotence rating scale was used. However at least two clients out of four, to whom it was administered complained that it forced them to focus on erection continuously and tended to have a negative effect on them. This poses the question whether this scale hampers therapeutic process instead of facilitating it. Possibly it could be administered weekly rather than daily was done in two cases in the present study. Followup data for a maximum period of three months shows that the therapeutic gains have been maintained over this period of time.

Although Masters and Johnson [6] initially recommended dual sex therapy team, other researchers have subsequently reported that dual sex therapy team may be luxury and not a necessity [7]. In the present study single therapist paradigm was used.

Use of single case design in the present study enabled the researcher to consider the sources of variability in the clients and to consider biological, cognitive and environmental variables.


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