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MODIFIED MASTERS JOHNSON TECHNIQUE IN THE TREATMENT OF SEXUAL INADEQUACY IN MALES

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SUMMARY

21 married men were treated for erectile defect and premature ejaculation (both primary & secondary) by modified Masters-Johnson technique. 16 (76.2%) recovered. The success rate was higher in secondary cases (83.3%). Best results were obtained in 30—39 yrs age group. The modified technique has been described in detail. Factors favourable and unfavourable for success have been discussed.

The treatment of sexual inadequacy devised by Masters and Johnson (Masters and Johnson, 1970) has brightened up the prospects of recovery of this intractable human problem. In the recent past several reports of treatment of sexual dysfunction have been published by Indian authors (Bagadia et al,, 1983; Agarwal, 1975; Kuruvilla 1975, 1984). These workers have used behavioural techniques based on those of Masters and Johnson (1970) and Wolpe (1973). The recovery rates reported by these authors are by and large lower than those of Masters and Johnson (1970). This communication presents the findings of treatment of sexual inadequacy in males by modified Masters and Johnson technique. This modification made the original technique simpler without any loss of its efficacy.

Material and Methods

The Sample consisted of 21 married males aged 25 to 44 years who were referred to the first author by a psychiatrist (D. N.) during a period extending from January, 1983 to June, 1986. All these cases belonged to urban middle class families and were engaged in white collar jobs. All the cases were examined physically and probable organic causes were excluded. Thirteen of these cases developed depression after the onset of sexual inadequacy and were on antidepressants (TCA) on the advice of the psychiatrist. This group (13) was put on modified M-J technique along with antidepressants. The other group (8) was on modified M-J technique only. Duration of treatment—a minimum of 15 and a maximum of 25 weekly sessions (one hour each) was the duration of treatment. The number of session was tailor made for each case on the basis of quality and quantity of response to treatment. He who did not respond even after 25 sessions was considered to be an unsuccessful case. Those who reported satisfactory coitus during the period of treatment and continue to perform well for at least two months on follow-up were considered successful ones. All the cases were treated along with their wives.

Definition of a case : These cases had either erectile defect or premature ejaculation or both. Both these types of defects were lumped together for the

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purpose of this presentation. But they have been shown separately on the basis of primary or secondary nature of their defects. Erectile defect was operationally defined as failure to obtain an erection sufficient for intromission. Premature ejaculation was the condition in which ejaculation occurred involuntarily before intromission. Primary erectile defect was defined as a case who could never have a successful intromission in his life. One who had it in the past but developed the defect later was a case of secondary erectile defect. Similar was the basis of sub-classification of primary and secondary premature ejaculation.

Technique of Therapy: On the first appointment the husband and the wife were interviewed separately. Each of them was encouraged to talk about his/her presenting problems of sexual life in marriage. Their attitude towards sex and past sexual experiences were obtained through semistructured interview technique. A sort of therapeutic alliance was made by explaining the therapeutic process that would follow.

The next two to three sessions were conducted as round table discussion amongst the husband, wife and therapist. At the outset it was made clear to the partners that the sexual problem is not his/her personal problem. It is a shared problem. For its solution the husband and the wife must be treated as a unit. At this stage the misconceptions and lack of knowledge about normal sex specific for both the partners were removed by discussion and presentation of pictorial charts and models. Scientific facts of reproductive biology and human sexuality were imparted with emphasis on the following points: (a) Sexual functioning is a naturally occurring phenomenon (b) Basic similarity between male and female sexual functioning (c) There is a common human sexual response cycle. Common human sexual response cycle was explained as passing through stages of (i) excitement phase (ii) plateau phase (iii) orgasm (iv) restoration phase. Any kind of blockage at any stage of this sexual response cycle creates sexual inadequacy. Anxiety, tension, social pressure, lack of privacy or serious emotional break down of any partner are some of the impediments on the road to smooth progress of the cycle to its completion. Hence the male partner was instructed on the technique of relaxation. It consists of a series of techniques by which an individual can relax his body part by part. When he gains a full relaxation of his whole body, relaxation of the emotional tension also occurs. He was encouraged to rehearse the technique in the clinic and repeat it at home. When the wife was found to be tense, anxious and inhibited she also was put on relaxation technique. The couple was instructed to learn these techniques by repeated efforts at home and to make a written report on it to the therapist during the next visit. The reports were discussed separately with each partner and necessary instruction was given. When the therapist considered that the couple was ready to pursue a common goal, the next programme was initiated.

"Sensate Focus" Programme—This programme involves a method of learning in stages for both the partners conjointly. The objectives of this programme are (i) to re-establish communication between the partners (ii) to enable each partner to play the dual role of giving pleasure to and getting pleasure from the other partner. Before initiating the couple to the sensate focus programme it was given as a dictum that there were certain do's to be performed sincerely and certain don'ts to be avoided absolutely. Any breach in their observance would vitiate the

whole programme and the treatment would be unsuccessful.

Sensate focus programme passes through two stages. *First stage* consists of (i) learning the technique of touching different parts of the partner's body except the genital organs (ii) communicating to the partner what he/she feels pleasurable or otherwise (iii) touching the genitals is strongly prohibited. This technique should be learnt by placing the male partner in a passive role and the female partner taking the active role and vice versa. From the first day of sensate focus programme both the husband and wife are instructed to keep a daily record of his/her experience of sex-play separately and confidentially and to present it to the therapist during the next visit. On the basis of this report the partners were counselled. The content of counselling was determined by each partner's personal problems, impediments and progress. On the basis of a couple's progress report the therapist would decide when the second stage of the sensate focus programme would begin.

Second stage of sensate focus programme consists of (i) mutual stimulation of the genital organs without striving for orgasm (ii) learning and telling each other what is most satisfying as genital stimulation technique (iii) refraining from any attempt at intromission to test his virility. Instructions about position of the partners during this programme were given. Non-demanding position for female genital stimulation was demonstrated by pictures. At this stage the wife was given specific instruction on 'squeeze technique (see Appendix) of glans penis in the cases of premature) ejaculation. 'Teasing method' (See Appendix) was explained to all the couples irrespective of the nature of the sexual dysfunction of the husband (erectile defect/premature ejaculation). During the second stage of sensate focus programme the written report of the couple was scrutinized more carefully. The progress of the programme was monitored and the impediments in progress were dealt with by the psychoanalytical technique of "Interpretation". The male partner was confronted directly and separately and his insight into the role of unconscious traces of childhood experiences in the adult sexual behaviour was augmented. This exercise was tailor-made for each male partner on the basis of his unique personal background.

To minimize the male's sex inhibition he was advised to go through sex fantasy. The reading of erotic stories and the exposure to erotic pictures often heightened the erotic pleasure.

After pursuing the second stage of sensate focus for a varying number of weeks most males could get a sustained erection without ejaculation. At this stage the couple was instructed to attempt coitus. Lateral coital position was advocated and demonstrated pictorially. The precoital techniques should be performed in this position and the wife was instructed to take an active part in inserting the erect penis in her genital organ. The husband should be passive at this initial stage and take the active part once intravaginal erection is maintained long enough for full satisfaction of both the partners.

Results :

The overall success rate in the present sample was 76.2%. The best results are obtained in the 30—39 yr. age group.

The recovery rate in the primary cases was 75.3% while the rate in secondary group is slightly higher (83.3%).

Best results are obtained in the cases who suffered for a period ranging between 1 year and 3 year (90.9%). Res-

Table 1—*Distribution of successful and unsuccessful cases by age.*

Age (in years)	Successful	Unsuccessful	Total
25—29	2(66.7)	1(33.3)	3
30—34	8(80)	2(20)	10
35—39	4(80)	1(20)	5
40—44	2(66.7)	1(33.3)	3
Total	16(76.2)	5(23.8)	21

Figures in parenthesis are percentages calculated horizontally.

Table 2—*Success rate amongst Primary & Secondary cases by age.*

Age (in years)	Primary (N=15)		Secondary (N=6)	
	Successful	Unsuccessful	Successful	Unsuccessful
25—29	2(66.7)	1(33.3)	—	—
30—34	5(71.4)	2(28.6)	3(100.0)	—
35—39	2(66.7)	1(33.3)	2(100.0)	—
40—44	2(100.0)	—	—	1
Total	11(73.3)	4(26.7)	5(83.3)	1(16.7)

Figures in parenthesis are percentage calculated horizontally.

Table 3—*Outcome of treatment according to duration of illness.*

Duration	No. of cases	Number of successful cases
Less than 1 Yr.	2	1 (50.0)
1 Yr.—3 Yrs.	11	10 (90.9)
3 Yrs.—5 Yrs.	5	4 (80.0)
More than 5 Yrs.	3	1 (33.3)
Total	21	16 (76.2)

Figures in parenthesis are percentages calculated horizontally

ponse to treatment is unsatisfactory if duration of illness is more than 5 years (33.3%).

Table 4—*Outcome of treatment according to method of treatment.*

Method of Treatment	No. of successful cases	No. of unsuccessful cases	Total
Modified M & J Technique & drugs	10(76.9)	3(23.1)	13
Modified M & J Technique	6(75.0)	2(25.0)	—
Total	16(76.2)	5(23.8)	21

Figures in parenthesis are percentages calculated horizontally.

The response to treatment was almost equal in both the groups. Cases requiring drug treatment for depression responded to M-J technique satisfactorily.

Discussion

The modification introduced into the M-J technique involves both its structure and function. Unlike the M-J technique no co-therapist was involved in any stage of treatment. Through several years experience with the application of this technique the first author was convinced that a single therapist was as effective as the team consisting of a therapist and a co-therapist. This simplification of the structure of the team made it more accessible to the patients.

The second modification was the application of some of the Psychoanalytical techniques to the M-J technique. By virtue of her training in the principles and practice of psychoanalysis, the first author was professionally inclined to experiment with some of the analytical techniques. By preliminary exploration of

the early childhood experiences of some cases who were poor responders to behaviour therapy, the author gained the insight that traces of adverse childhood experiences play an important role in the adult sexual behaviour in health and in illness. This insight led her to introduce the technique of interpretation into behaviour therapy of Masters and Johnson. Results, as shown by the present study, was encouraging. The technique was to explore the childhood experiences of each patient through his self-report and to single out the adverse experiences and complexes for interpretation. The following themes were common in most cases : Parental dominance, neurotic fear of damaging the male organ during intromission and extreme passive wish of the male interfering with his gender role in sexual behaviour. The interpretation of these themes led to clearer insight of the patient into their deleterious influences on symptom formation. This newly gained insight accelerated the progress of treatment.

The rate of satisfactory restoration of sexual function in our sample was 76.2% (Table I). Kuruvilla (1975) reported a success rate of 54%. Bagadia et al. (1983) reported a success rate of 58% and Kuruvilla's (1984) recent study showed a success rate of 54%. Though Agarwal (1975) reported better results, the high rate of drop out in his series makes any conclusion difficult. All these studies were made on the basis of behavioural techniques. The combination of behavioural directive technique and the psychodynamic interpretational technique (as done in the present study), may have yielded better result. It must, however, be borne in mind that the samples of these Indian studies may not be comparable in all respects. Inspite of this limitation, the difference between the success rates of two methods of treatment on these samples deserves more than a passing glance. O'Connor (1976) reviewed the literature on the treatment of sexual dysfunction and came to the conclusion that behaviour therapy produced better result than psychotherapy or psycho-analysis. As we could not trace any Indian report on the treatment of sexual inadequacy by psychoanalysis, it is difficult to comment on this generalization in the Indian context. The present study, however, suggests that the combination of some of the psychoanalytical techniques with behaviour therepy produces better results than behaviour therapy alone. In the present study primary dysfunction showed a success rate of 73.3% while that of secondary dysfunction was 83.3% (Table II). The outcome of secondary dysfunction seems to be much better than primary dysfunction in this sample. More important is the fact that Masters and Johnson (1970) reported a success rate of 73.8% in secondary cases treated by their technique. Wolpe (1973) cured 14 out of 18 cases in eight weeks (cure rate 77.7%). The results of the present study compare favourable with studies undertaken with behavioural techniques in the West.

So far as ages of the subjects are concerned the largest single group belongs to 30-39 years and this age group had the best outcome. Patients suffering for 1 year to 3 years responded best to the treatment, 90.9% cure rate. These results are in the tune with other Indian studies (Bagadia et al., 1983). The patients who were on modified M-J technique alone showed a cure rate of 75% while those who were prescribed drugs (TCA) along with modified M-J technique had a cure-rate of 78.9% Associated depression and administration of antidepressants did not influence the outcome of sexual inadequacy in our sample. The almost iden-

tical cure-rate possibly nullifies the argument that recovery from depression is invariably associated with recovery from sexual inadequacy. It may be noted here that all the 13 cases who were on drugs (TCA) were free from depression at their final assessment. But three of them (23.1%) were adjudged unsuccessful cases as far as the treatment of sexual inadequacy was concerned. Some of the factors which stand in the way of better results in Indian samples lie in their ignorance, attitude, practice and taboos concerning sexual life. Where abstinence is glorified as a precondition to salvation of the spirit, carnal pleasure must be at a discount. Even marital sex often loses its natural spontaneity. The idea of purity and contamination is entangled with it. This culturally conditioned value system played an indirect role in the initiation and perpetuation of sexual inadequacy in some of our cases. This may be true for many other men brought up in a similar orthodox cultural milieu. Behaviour therapy, in our view, does not take care of this stumbling block on the road to recovery of these cases. The wives, by their non-cooperation, make the situation desperate. They often consider marital sex a gift from the husband. Though they understand the consequence of the sexual problem for which their husbands seek medical advice, their built-in inhibitions prevent them from participating in a conjoint programme of sex-therapy spread over a considerable period of time. These women often get frightened by the spectre of pregnancy. This is particularly so for the secondary cases. The *social* pressure created on the couple in a joint family by the lack of privacy and excessive interference of the in-laws in their conjugal life retards the progress of treatment. Some couples continue to report about the difficulty of pursuing therapeutic direction. Such a situation often undermines the motivation of the couple to continue with the course of treatment.

This adverse social situation is at times compounded with adverse *personality* traits of the partners. Some husbands were so self centred that they could not open up their minds even to their wives during the round table discussion with the therapist. Any conjoint therapy is bound to be less effective in these cases. If these men are to participate in a behaviour therapy session with a partner who has a hysterical personality with dependency need, the pressure of performance evokes anxiety in their mind and therapy is doomed to fail.

Here lies the rationale of introducing some of the psychoanalytical techniques in behaviour therapy. The cultural, social and personality factors responsible for tardy progress of some patients on behaviour therapy are taken care of by these techniques. As the therapeutic alliance is struck in the initial session a bond of understanding between the patient and therapist is developed and sustained during the course of treatment. This bond of understanding enhances the effectiveness of the procedure and diminishes the patient's anxiety that arises on the discovery of the sexual inadequacy. The sustenance of this bond is facilitated by the therapist's non-critical permissive stance in dealing with the patient. A dominant mother or a punitive father of his early childhood might have engendered unconscious psychological forces which influenced his sexual behaviour in adult life. The therapist takes the role of a non-critical permissive parent and possibly a mechanism of encouragement sets in. A parent often does not attain the culturally accepted dominant gender role in sex behaviour owing to unconscious passive needs. The therapist's encouragement to take up the passive

role in sexual performance saved him from the inevitable conflict and paved the way to success of the treatment.

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APPENDIX

Squeeze Technique

It should be practised by the wife in the following manner : As soon as the husband achieves full erection the wife places her thumb on the frenulum of the penis and the index and middle fingers on the dorsum of the penis on either side of the coronal ridge. Pressure is applied by firmly squeezing the thumb and the fingers together for three to four seconds. The husband at once loses his erection and urge to ejaculate. After a lapse of about half a minute the sensate focus technique is resumed and when the full erection is achieved the squeeze technique is repeated. In one session ten to fifteen such repetitions may be done.

Teasing Technique

This technique is followed after the husband has attained erection for the first time. When husband and wife by sensate focus technique succeeds in gaining the penile erection they are advised to allow the husband to lose it by stopping the foreplay and by distraction. Then the foreplay is resumed and continued till the erection reappears. Again the husband is allowed to lose it and regain it by the same method of foreplay. This is continued for a full half-hour in a slow, non demanding position. This technique is called teasing technique. This technique enhances the pleasure and confidence of both the partners.