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# Evaluation of *Stambhanakaraka Yoga* and counseling in the management of *Shukragata Vata* (premature ejaculation)

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## Abstract

Premature Ejaculation (PE) is a very common male sexual problem. Anxiety, stress, fear etc., are the main predisposing factors of PE. In Ayurveda, this condition can be correlated with *Shukragata Vata*. In the present study, fifty five patients with PE were grouped into two and were treated with *Stambhanakaraka Yoga* (*n* = 30) and Placebo (*n* = 20) for a duration of two months, with luke warm water as *anupana*. Psychological counseling was given to the patients in both the groups. After completion of treatment, *Stambhanakaraka Yoga* showed significant results against placebo in all parameters, namely Intravaginal Ejaculation Latency Time (IELT), voluntary control over ejaculation, patient and partner's satisfaction, performance anxiety.

**Key words:** Placebo, premature ejaculation, *Shukragata Vata*, *Stambhanakaraka Yoga*

## Introduction

Premature ejaculation is generally regarded as one of the most common male sexual dysfunctions. Ejaculatory response is the efferent (motor) component of a spinal reflex that typically begins with sensory stimulation to the glans penis.[1] However, much less is known about this disorder than erectile dysfunction and there is a lack of a commonly accepted definition for this complaint. A specific ejaculatory latency was not defined because of the absence of normative data.[2] Ejaculation must occur before or very soon after.[3] Premature ejaculation is a very common male sexual disorder, affecting on an average 40% of the men worldwide.[4] The World Health Organization (WHO) Second International Consultation on Sexual Health defined it as, "persistent or recurrent ejaculation with minimal stimulation before, on, or shortly after penetration and before the person wishes it, over which the sufferer has little or no voluntary control, which causes the sufferer and/or his partner bother or distress".[5] An increased susceptibility to premature ejaculation in men from the Indian subcontinent has been reported.[6] Most modern research uses the Intravaginal Ejaculatory Latency Time (IELT) as measured by a stopwatch.[7] This technique, which was originally used by a psychoanalyst in 1973,[8] has become the standard because of a study by the Dutch scientists.[9]

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*Vajikarana* (aphrodisiac therapy) is one of the eight branches of *Ayurveda* that deals with the preservation and amplification of the sexual potency of a healthy man and conception of healthy progeny as well as management of defective semen, disturbed sexual potency, and spermatogenesis, along with treatment of seminal-related disorders in man.[10] *Vajikarana* promotes the sexual capacity and performance as well as improves the physical, psychological, and social health of an individual.[11] In Ayurveda there is a concept of *Shukragata Vata*, which can be correlated with Premature Ejaculation.

*Shukragata Vata* is a distinct pathological entity, characterized by a group of clinical presentations either related to the impairment of ejaculation or with the impairment of seminal properties. The clinical presentations of *Shukragata Vata* are early ejaculation, delayed ejaculation, affliction of fetus/premature birth.[12]

Different clinical presentations of the same pathological process occur according to the effect of the vitiated *vata* on various structural and functional attributes of *shukra*. In delayed ejaculation, although intravaginal ejaculation eventually occurs, it requires a long time and strenuous efforts at coital stimulation, and sexual arousal may be sluggish. It may be caused when the vitiated *vata* loses its *drutatva* or *chalatva* after the enlodgement, which leads to lack of sufficient stimulation (*prerana*) for ejaculation. It may also happen when the vitiated *vata* causes diminution of *Shukra Dhatu by Shoshana Svabhava*, and quantitatively less amount of *Shukra* is ejaculated after a long effort.[13] Seminal parameters are impaired when the vitiated *vata* afflicts the functional characteristics of *Shukra*, such as semen or spermatozoa. When *Vata* affects these characteristics, *Shukra Dushti* is explained as *Phenila*,

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*Tanu, Rooksha,*[14] *Grathita, Vivarnadi Yukta,*[15] *Vatika Shukra, Granthishukra (Vata-Kaphaja), Ksheena (Vata-Paittika),*[16] *Alpa Retas, Ksheena Retas, and vishushka Retas*[17] occurs. These are seminal abnormalities lacking in the qualities of count (azoospermia or oligospermia), motility (asthenospermia), and morphology (teratospermia). The physical properties of semen like volume, viscosity, appearance, transparency, and so on, may also be impaired due to *vata* vitiation.

For this study, '*Stambhanakaraka Yoga*' containing *Tulsi Beeja* (*Occimum santum* Linn.), *Akarakarabha* (*Anacyclus pyrethrum* Linn.), *Mishri* (sugar) recommended in a classical book '*Chikitsa Chandrodaya*'[17] was undertaken as trail drug. The present study was designed with the objectives of understanding premature ejaculation in Ayurvedic parlance in terms of *Shukragata Vata* and to evaluate the efficacy of the classical formulation, '*Stambhanakaraka Yoga*' in the management of *Shighra Skhalana* (PE).

## Materials and Methods

Patients attending the *Vajeekarana* Out Patient Department (OPD) of Department of Kaya Chikitsa, IPGT and RA, Hospital, Gujarat Ayurved University, Jamnagar, having genuine complaints of premature ejaculation fulfilling the criteria for inclusion, were selected irrespective of race, caste, or religion, between the age group of 21 and 50 years. The pre-entry examination was simple and brief and tried to include an interview of patient's wife wherever it was possible.

### Inclusion criteria

Considering the different definitions put forth by various scientists for premature ejaculation, the inclusion criteria for the present study were as follows:

1. Ejaculation prior to ten penile thrusts
2. Ejaculation before, on, or within one minute of the sexual act after penetration
3. Unable to satisfy partner in at least 50% of the coital incidences
4. Unable to delay ejaculation till the person wishes it
5. The problem should be persistent or recurrent and cause marked distress or interpersonal difficulties.

### Exclusion criteria

1. The factors that affect the duration of the excitement phase of sexual act such as novelty of the partner or situation and recent frequency of the sexual act is taken into account
2. The problem should not be exclusively due to the direct effect of a substance (e.g. withdrawal of opioids)
3. Persons having very short post ejaculatory refractory period.
4. Major psychiatric illness
5. Any other major pathology.

### Drug and dose

The selected patients were randomly divided in two groups. Patients in group A were administered *Stambhanakaraka Yoga* (*Aakarkarbha* (*Anacyclus pyrethrum* Linn.) two parts, Seeds of *Tulasi* (*Occimum santum* Linn.) four parts, and *Mishri* (Sugar) eight parts in powder form) in a dose of 6 g twice a day, before lunch and supper, with *Koshna Jala* (lukewarm water) as *Anupana*, for a duration of two months. In group B Placebo (starch powder) was administered with same dose and *anupana*. Psychological counseling was done in both the groups.

*Haritaki* powder (*Terminalia chebula* Retz.) was given, 6 g at bed time for *Koshta Shudhi* (bio-purification) for three days, before starting the medication. All the patients were directed to keep the frequency of sexual act and duration of foreplay as they were always adopting, so that a change in them would not make an error in the evaluation of therapy. A generalized moderate *Pathyapathya* were advised to all patients.

### Investigations

Complete Blood Count, Urine (Routine and microscopic), Semen Analysis (Before treatment and after treatment) were carried out.

### Criteria of assessment

Improvement in the patient was assessed mainly on the basis of relief in the signs and symptoms of the disorder. To assess the effect of therapy objectively, all signs and symptoms were given a score depending upon their severity. Related signs and symptoms were recorded from the first day - starting on the day of treatment followed by weekly or daily observation during the course of treatment. Gradation of the symptoms was done depending on the severity and specific symptom score prior to treatment and after completion of the treatment, and their difference was assessed.[18]

**Gradation of cardinal symptoms**

| Symptom | Score |
|---|---|
| Intravaginal ejaculatory latency time less than one minute | |
| Mere thought, sight, or voice of partner | 5 |
| Immediately after penetration | 4 |
| Within 30 seconds of penetration | 3 |
| Within two minutes | 2 |
| Within two to five minutes | 1 |
| More than five minutes | 0 |
| Voluntary control over ejaculation | |
| Never | 5 |
| Lack of control on most occasions | 4 |
| Less than 25% encounter | 3 |
| Less than 50% encounters | 2 |
| Less than 75% encounters | 1 |
| Full control over ejaculation | 0 |
| Patient satisfaction | |
| No orgasm at all | 5 |
| Lack of enjoyment | 4 |
| Satisfaction during 25% of the sexual act | 3 |
| Satisfaction during 50% of the sexual act | 2 |
| Satisfaction during 75% of the sexual act | 1 |
| Satisfaction during every sexual act | 0 |
| Partner's satisfaction | |
| No orgasm at all | 5 |
| Lack of enjoyment | 4 |
| Satisfaction during 25% of the sexual act | 3 |
| Satisfaction during 50% of the sexual act | 2 |
| Satisfaction during 75% of the sexual act | 1 |

*(Contd.)*

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| | |
|---|---|
| Satisfaction during every sexual act | 0 |
| Performance anxiety | |
| Anxiety that hampers all encounters | 5 |
| Anxiety that hampers the sexual act in 75% of the encounter | 4 |
| Anxiety that hampers the sexual act in 50% of the encounter | 3 |
| Anxiety that hampers the sexual act in 25% of the encounter | 2 |
| Slight anxiety that does not disrupt the sexual act | 1 |
| No anxiety at all | 0 |
| Number of penile thrusts | |
| None, discharge before penetration | 5 |
| Less than 5 | 4 |
| Less than 10 | 3 |
| Less than 15 | 2 |
| Less than 20 | 1 |
| More than 25 | 0 |

### Total effect of therapy

Considering the relief of major symptoms and improvement in the quality of sexual functioning, the subjects were divided into the following groups, to assess the total efficacy of each therapy.

1. Cured (100%) – achievement of certain reasonable voluntary control over ejaculation, sufficient length of the sexual act according to the wish, with both partners satisfied.
2. Markedly improved (>75-<100%) – sufficient length of sexual act according to wish, with both partners satisfied, but no voluntary control over ejaculation.
3. Moderately improved (>50-75%) – improvement in duration of sexual act of more than one minute or more than ten penile thrusts with partner's satisfaction in at least 50% of the incidents.
4. Improved (25-50%) – duration of sexual act less than one minute or less than 10 penile thrusts.
5. Unchanged (<25%) – no change or worsening of duration of sexual act or other sexual health parameters like erection, rigidity.

## Observation and Results

A total of 55 patients were registered. Out of 32 patients registered in Group A, 30 completed treatment and two dropped out. In Group B, overall 23 patients were registered, out of which three dropped out and 20 completed the treatment. In Group A, the intravaginal ejaculatory latency time improved by 50.64%, voluntary control over ejaculation improved by 56.17%, subjects satisfaction improved by 59.78%, partner satisfaction improved by 38.46%, performance anxiety improved by 42.52%, and number of penile thrusts improved by 13.97%. Improvement of patient satisfaction, partner's satisfaction, and number of penile thrusts were statistically highly significant ($P < 0.001$). IELT, voluntary control over ejaculation, and performance anxiety were also highly significant ($P < 0.001$) [Table 1].

In Group B, the intravaginal ejaculatory latency time improved by 24.41%, voluntary control over ejaculation improved by 26.19%, subjects satisfaction improved by 15.27%, partner satisfaction improved by 18.64%, performance anxiety improved by 17.72%, and the number of penile thrusts improved by 5.88%. Improvement in partner's satisfaction and number of penile thrusts were statistically highly significant ($P < 0.001$). IELT, voluntary control over ejaculation, and performance anxiety were also highly significant ($P < 0.001$) [Table 2].

The effect of *Stambhanakaraka Yoga* on modified scale for premature ejaculation based on Griss questionnaire showed highly significant improvement in Group A [Table 3], while it was insignificant in Group B [Table 4].

*Stambhanakaraka Yoga* has shown highly significant results on *Manasikbhavas* (emotions) with regard to *Harsha* ($P < 0.001$), *Preeti* ($P < 0.001$), *Veeryam* ($P < 0.001$), *Bhaya* ($P < 0.001$), and *Avasthanam* ($P < 0.001$). Improved results were seen with regard to *Raja* ($P < 0.05$), *Krodha* ($P < 0.05$), and *Dhriti* ($P < 0.05$). Insignificant results were seen in *Medha* ($P > 0.05$) [Table 5].

Placebo showed highly significant results, on *Harsha* ($P < 0.001$), *Preeti* ($P < 0.001$), *Veeryam* ($P < 0.001$), and *Shraddha* ($P < 0.001$. Improved results were seen in *Raja* ($P < 0.05$), *Harsha* ($P < 0.01$), *Bhayam* ($P < 0.01$), *Medha* ($P < 0.05$), and *Dhriti* ($P < 0.01$). Insignificant results were seen in *Krodha* ($P > 0.05$) [Table 6].

The effect of therapy on Hamiltons anxiety rating scale showed statistically highly significant improvement ($P < 0.001$) by *Stambhanakaraka Yoga*, while statistically significant improvement ($P < 0.05$) was reported in Placebo group [Table 7].

In Group A, 7.14% patients got complete relief, while no patient in Group B were completely cured. Maximum patients (67.86%) in Group A had reported marked improvement, while 5.88% in Group B were markedly improved. 21.43% patients in Group A and 11.76% in Group B were moderately improved. 3.57% patients in Group A and 82.35% in Group B were unchanged [Table 8].

## Discussion

The mean intravaginal ejaculatory latency time in Group A and B was statistically highly significant ($P < 0.001$). As the disorder had a huge psychological component; counseling had a big role to play. The percentage of improvement was more than double in Group A compared to group B. Voluntary control over ejaculation improved in both Groups A and B, with statistical significance of $P < 0.001$. Patient satisfaction improved in both the groups with statistical significance, because of the effect of *Stambhanakaraka Yoga* on *Vata* and *Manas*. As rejuvenated *Manas* improved *Harsha*, *Dhairya*, and *Preeti*, encouraging results were seen in Group A. Partner satisfaction was highly significant ($P < 0.001$) in both Groups of A and B. The fact that the subject was taking treatment made the spouse feel that her partner was having a problem and made her compromise a little during the act, due to which the patient felt that he was improving. This could be the reason that the placebo group also showed statistically significant results. However, the percentage of improvement was two times more in group A than in group B. The performance anxiety was considerably reduced in

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**Table 1: Effect of *Stambhanakaraka Yoga* on the chief complaints of PE (*n*=30)**

| Symptoms | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| Intravaginal ejaculatory latency time | 1.85 | 50.64 | 0.91 | 0.19 | 9.35 | <0.001 |
| Voluntary control over ejaculation | 2.38 | 56.17 | 1.11 | 0.24 | 9.76 | <0.001 |
| Patient satisfaction | 2.61 | 59.78 | 0.74 | 0.16 | 16.21 | <0.001 |
| Partner's satisfaction | 1.19 | 38.46 | 0.98 | 0.21 | 5.56 | <0.001 |
| Performance anxiety | 1.76 | 42.52 | 0.62 | 0.13 | 12.92 | <0.001 |
| Number of penile thrusts | 0.61 | 13.97 | 0.59 | 0.12 | 4.81 | <0.001 |

PE: Premature ejaculation

**Table 2: Effect of *Placebo* on the chief complaints of PE (*n*=20)**

| Symptoms | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| Intravaginal ejaculatory latency time | 1.05 | 24.41 | 0.82 | 0.18 | 5.68 | <0.001 |
| Voluntary control over ejaculation | 1.10 | 26.19 | 0.85 | 0.19 | 5.77 | <0.001 |
| Patient satisfaction | 0.55 | 15.27 | 0.75 | 0.17 | 3.24 | <0.01 |
| Partner's satisfaction | 0.55 | 18.64 | 0.60 | 0.13 | 4.06 | <0.001 |
| Performance anxiety | 0.70 | 17.72 | 0.57 | 0.12 | 5.48 | <0.001 |
| Number of penile thrusts | 0.25 | 5.88 | 0.44 | 0.09 | 2.51 | <0.05 |

PE: Premature ejaculation

**Table 3: Effect of *Stambhanakaraka Yoga* on modified scale for PE based on GRISS Questionaire (*n*=30)**

| Questions | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| Are you able to delay ejaculation during intercourse if you think you may be coming too quickly? | 1.55 | 47.02 | 0.57 | 0.10 | 14.55 | <0.001 |
| Can you avoid ejaculation too quickly during intercourse | 1.58 | 47.58 | 0.73 | 0.13 | 11.65 | <0.001 |
| Do you ejaculate without wanting to almost as soon as your penis enters your partner's vagina? | 1.62 | 46.75 | 0.86 | 0.16 | 10.11 | <0.001 |
| Do you ejaculate by accident just before your penis is about to enter your partner's vagina? | 0.53 | 46.20 | 0.62 | 0.11 | 13.60 | <0.001 |

PE: Premature ejaculation

**Table 4: Effect of *Placebo* on modified scale for PE based on GRISS Questionaire (*n*=20)**

| Questions | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| Are you able to delay ejaculation during intercourse if you think you may be coming too quickly? | 0.41 | 17.62 | 0.51 | 0.13 | 3.38 | <0.01 |
| Can you avoid ejaculation very quickly during intercourse | 0.23 | 9.74 | 0.45 | 0.11 | 2.21 | <0.05 |
| Do you ejaculate without wanting to, almost as soon as your penis enters your Partner's Vagina? | 0.50 | 19.04 | 0.52 | 0.13 | 3.88 | <0.01 |
| Do you ejaculate by accident just before your penis is about to enter your partner's vagina? | 0.25 | 28.56 | 0.45 | 0.11 | 2.54 | <0.05 |

PE: Premature ejaculation

Group A and B with statistically high significance ($P < 0.001$). The reduction in the performance anxiety and improvement in the ejaculatory performance coincided, showing a strong positive correlation between them.

Improvement in the mean number of penile thrusts was highly significant ($P < 0.001$) in Group A and significant in Group B ($P < 0.05$). Considering the number of penile thrusts, the effect of therapy was more than double when compared to Placebo.

The ability to delay ejaculation and the severity of the problem were assessed with the four itemed subscale of the GRISS Questionnaire for high reliability and good validity. The first criterion enquired the 'ability to delay ejaculation during intercourse when he may think he may be coming too quickly,' this was aimed at understanding the maintenance of the internal cue, identification of ejaculatory inevitability, and voluntary control over ejaculation. Almost all the subjects answered 'never'. Statistically high significant improvements ($P < 0.001$) and ($P < 0.01$) were noted in Groups A and B, respectively. From the foregoing observations it could be inferred that *Stambhanakaraka Yoga* provided a certain degree of significant voluntary control over ejaculation in comparison with the placebo. This could be due to the direct effect of *Akarakarabha*

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and *Tulasi* on *Vata* especially on the *Apana Vata*. The effect could be due to the reduction in the shortness of nerve latency time or decrease in the rapidity of reflexes.

The second criterion was to examine whether the subject was enjoying the sexual act for a sufficient duration of time without early ejaculation. In Group A, the percentage of improvement was statistically significant ($P < 0.05$).

The third criterion was to enquire about the incidence of ejaculation immediately after penetration; 46.75% improvement was seen in Group A, which was statistically highly significant ($P < 0.001$) and 19.04% improvement was seen in Group B, which was statistically significant ($P < 0.01$).

The last criterion of the analysis is the incidence of ejaculation before penetration, which in group A was relieved in a statistically highly significant manner ($P < 0.001$). The improvement in group B was also statistically significant ($P < 0.05$).

Hence, in a nutshell it can be conceptualized that an ejaculation before penetration or just after penetration, and when purely the psychological factors are operating can be managed even with placebo and psychological counseling alone; whereas, *Stambhanakaraka Yoga* considerably increases the duration of the sexual act. This therapy is more efficacious in imparting a certain degree of voluntary control over ejaculation.

On Hamilton's anxiety rating scale, Group A improved in a statistically highly significant manner ($P < 0.001$), whereas, group B improved in a statistically significant manner ($P < 0.05$). From this it could be concluded that although only psychological counseling or Placebo was able to reduce anxiety to some extent, when psychological counseling along with *Stambhanakaraka Yoga* was given it provided encouraging results. The seminal parameters were nearly within the normal range [Table 9]. *Shukragata Vata* is a clinical condition characterized by early ejaculation, and inability to conceive. It was a matter of interest to know whether all the three symptoms co-existed in an individual inflicted with *Shukragata Vata*.

Placebo with psychological counseling was found to be effective to a certain extent in the management of PE. Simple psychological counseling could impart confidence and self-esteem in the subject, help him to think positively, and to indulge in the sexual act enthusiastically by reducing performance anxiety. The suggestions helped to avoid spectator effect so that sexual functioning would not deteriorate. His misconceptions regarding the act of copulation were solved, thus he followed the right techniques wherever and whenever necessary. *Dhee, Dhairya Atmsadi Vinjanam* is suggested to be an excellent *Oushadha* for *Manodosha*[19] (promotion of mental health), which is supplied through *counseling*. The placebo acts as a *Manosamvardhana Chikitsa*. The fact that he is taking medicine for his problem, and satisfaction that his unanswered questions related to the act of copulation have been answered through counseling could make the patient feel that his problem has improved.

*Stambhanakaraka Yoga* possesses *Vrishya*, *Balya*, *Medhya*, and *Shukra Stambhaka* properties. As *Vrishya* and *Balya* the drug enhances the quality of the *Shukra Dhatu* reducing *Dourbalya* and *Riktata* in the *Shukravaha Srotas*, by pacifying the aggravated *Gata Vata*. *Medhya* properties of the drug act biologically and improve the psychological functioning. The *Shukra Stambhaka* property by virtue of decreasing *Saratva* (responsible for *Prerana*) of the *Shukra Dhatu* and enhancing *Sthiratva* (which favors *dharana*), helps in the retention of semen for a longer duration. It also improves the strength of the individual by *Balya* property, which helps in sexual functioning., *Akarkarabha* has an immunostimulating activity,

**Table 5: Effect of *Stambhanakaraka Yoga* on *Manasbhavas* (*n*=30)**

| Symptoms | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| *Raja* | 0.30 | 45 | 0.70 | 0.12 | 2.34 | <0.05 |
| *Krodha* | 0.26 | 38.09 | 0.45 | 0.08 | 3.24 | <0.01 |
| *Harsha* | 0.73 | 78.57 | 0.69 | 0.12 | 5.80 | <0.001 |
| *Preeti* | 1.06 | 88.88 | 0.52 | 0.09 | 11.21 | <0.001 |
| *Bhayam* | 0.56 | 39.53 | 0.50 | 0.09 | 6.15 | <0.001 |
| *Veeryam* | 0.63 | 61.29 | 0.71 | 0.13 | 4.82 | <0.001 |
| *Avasthanam* | 1.26 | 80.85 | 0.63 | 0.11 | 10.84 | <0.001 |
| *Shraddha* | 0.76 | 76.66 | 0.77 | 0.14 | 5.42 | <0.001 |
| *Medha* | 0.06 | 25 | 0.25 | 0.04 | 1.43 | >0.05 |
| *Dhriti* | 0.3 | 81.81 | 0.53 | 0.09 | 3.07 | <0.01 |

**Table 6: Effect of *Placebo* on *Manasbhavas* (*n*=20)**

| Symptoms | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| *Raja* | 0.20 | 36.36 | 0.41 | 0.09 | 2.17 | <0.05 |
| *Krodha* | 0.05 | 11.11 | 0.23 | 0.65 | 1 | >0.05 |
| *Harsha* | 0.5 | 47.61 | 0.60 | 0.13 | 3.68 | <0.01 |
| *Preeti* | 0.7 | 50 | 0.5 | 0.13 | 5.38 | <0.001 |
| *Bhayam* | 0.5 | 3.33 | 0.51 | 0.11 | 4.35 | <0.01 |
| *Veeryam* | 0.6 | 60 | 0.50 | 0.12 | 5.33 | <0.001 |
| *Avasthanam* | 0.50 | 40 | 0.55 | 0.13 | 3.85 | <0.01 |
| *Shraddha* | 0.55 | 91.66 | 0.51 | 0.12 | 4.81 | <0.001 |
| *Medha* | 0 | 41.33 | 0.48 | 0.12 | 2.5 | <0.05 |
| *Dhriti* | 0.05 | 40.89 | 0.63 | 0.15 | 3.58 | <0.01 |

**Table 7: Effect of therapy on Hamilton's anxiety rating scale**

| Group | Mean | % | S.D. | S.E. | *t* | *P* |
|---|---|---|---|---|---|---|
| *Stambhanakaraka Yoga* | 0.76 | 71.87 | 0.43 | 0.07 | 9.76 | <0.001 |
| Placebo | 0.30 | 37.45 | 0.48 | 0.11 | 2.60 | <0.05 |

**Table 8: Overall effect of therapy**

| Group | Cured % | Markedly improved % | Moderately improved % | Unchanged % |
|---|---|---|---|---|
| *Stambhanakaraka Yoga* | 7.14 | 67.86 | 21.43 | 3.57 |
| Placebo | 00 | 5.88 | 11.76 | 82.35 |

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**Table 9: Seminal parameters**

| Seminal parameters | Studied sample | Normal values (WHO) |
|---|---|---|
| Liquefaction time (in minutes) | 22.42±12.63 | 20-30 |
| Viscosity (in cms) | 0.276±0.789 | |
| Volume (in cc.) | 2.746±1.268 | 1.5-5.0 |
| pH | 7.686±0.471 | 7.5-8.0 |
| Viability (%) | 68.73±15.96 | >60 |
| Sperm count (in millions) | 87.74±72.97 | >20 |
| Sperm motility (%) | | |
| RLP | 6.65±12.57 | >25 |
| SLP | 44.37±12.64 | >50 |
| Non-progressive | 11.8±8.727 | |
| Immotile | 38.42±11.4 | |
| Total abnormal forms (%) | 81.54±9.45 | <70 |
| Auto agglutination (%) | 7.14±15.35 | <20 |

WHO: World health organization

aphrodisiac and reproductive activities, and antidepressant property. On pharmacological analysis *Anacyclus pyrethrum* increases the sexual potency in rats. *Tulasi* seeds have anti-nociceptive action and anti-stress activity. Therefore, *Stambhanakaraka Yoga* possesses aphrodisiac, immunomodulatory, anti-stress, and anti-oxidant properties. On account of these properties *Stambhanakaraka Yoga* is useful for disintegrating the pathophysiology of premature ejaculation.

*Shukragata Vata* denotes a group of disorders with different symptomatologies, which may not necessarily coexist. The seminal parameters of the patients were within the normal range, indicating the non-coexistence of *shukra vikriti* with *sheeghra shukrotsarga* in cases of *Shukragata vata*. The psychological component of the disease is very strong, therefore, psychosexual counseling is a must. Placebo or psychological counseling is not sufficient to control a vitiated *Vata*, especially in subjects having behavioral conditioning or physiological shortness of nerve latency time. *Stambhanakaraka Yoga* possesses *Vrishya*, *Balya*, *Medhya*, and *Shukra Stambhaka* properties.

## Conclusion

*Stambhanakaraka Yoga* by virtue of its properties biologically acts as a psychotropic, improves the duration of the sexual act, and reduces performance anxiety. *Stambhanakaraka Yoga* along with psychological counseling is most effective in the treatment of *Shukragata Vata*. Anxiety and Stress are the triggering factors for Premature Ejaculation. Therefore, while treating a patient with premature ejaculation, psychological counseling is a must. However, Placebo alone with psychological counseling is not able to achieve voluntary control. Hence, when a *Vrishya* drug, having *Balya*, *Medhya*, and *Shukrastambhaka* properties is used along with psychological counseling, then it provides encouraging result in Premature Ejaculation.

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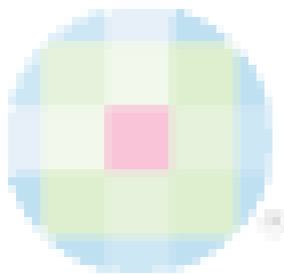
# हिन्दी सारांश

# शुक्रगत वात की चिकित्सा में स्तंभनकारक योग का चिकित्सिय अध्ययन

प्रसाद वी. कुलकर्णी, हरिमोहन चन्दोला

पुरुषों में शीघ्र स्खलन एक बहुत ही ज्वलंत समस्या है । चिंता, भय, शोक आदि शीघ्र स्खलन के मुख्य कारण हैं । आयुर्वेद की दृष्टि से इस अवस्था को शुक्रगत वात के रुप में समझा जा सकता है । शीघ्र स्खलन से ग्रस्त ५० रुग्णों को २ वर्गो में विभाजित किया गया एवं चिकित्सार्थ १) स्तंभनकारक योग (*n*=30) और २) प्लॅसिबो चिकित्सा २ माह तक कोष्ण जल अनुपान के साथ दी गई । दोनों वर्गों में सामयिक रुप से मानसिक अनुपदेशन दिया गया । चिकित्सा के बाद स्तंभनकारक योग वर्ग में, प्लॅसिबो की तुलना में सभी मापदण्डों पर यथा–IELT, वीर्यस्खलन पर ऐच्छिक नियंत्रण, रुग्ण और सहचारी की तृप्ति, चिंता आदि में सांख्यिकी दृष्टि से महत्त्वपूर्ण लाभ हुआ ।



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