Clinical Research

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

Prasad V. Kulkarni, Harimohan Chandola
Assistant Professor, Department of Kaya Chikitsa, BSDT’S Ayurved College, Wagholi, Pune, Maharashtra,
Director, Chaudhary Brahmi Prakash Ayurved Charak Sansthan, Khera Dabar, Najafgarh, New Delhi, India

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]

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 spermatogenesis. When Vata affects these characteristics, Shukra Dushti is explained as Phenila,
For this study, ‘Stambhanakaraka Yoga’ containing Tulsi Beeja (Ocimum sanctum Linn.), Akararakaraha (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 (Aakarkarabha (Anacyclus pyrethrum Linn.) two parts, Seeds of Tulasi (Ocimum sanctum 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.

**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.\(^{[18]}\)

| Gradian of cardinal symptoms | 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 |

**Patent satisfaction**

| Partner's satisfaction | No orgasm at all | Lack of enjoyment | Satisfaction during 25% of the sexual act | Satisfaction during 50% of the sexual act | Satisfaction during 75% of the sexual act |
|------------------------|------------------|------------------|----------------------------------------|----------------------------------------|----------------------------------------|
| 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 |

\(^{(Contd.)}\)
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 10 3
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 25 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 5.85%. 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), Bhaya (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 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|

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 |

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|

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 |

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 Questionaire 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.
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, Dhairyatmadi Vijnanam is suggested to be an excellent Oushadha for Manodoshas (promotion of mental health), which is supplied through counseling. The placebo acts as a Manomulavardhini 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 Vrisha, Balya, Medhya, and Shukra Sambhak properties. As Vrisha and Balya the drug enhances the quality of the Shukra Dhatu reducing Dourbalya and Rikata in the Shukravata Sroitas, by pacifying the aggravating Gata Vata. Medhya properties of the drug act biologically and improve the psychological functioning. The Shukra Sambhak property by virtue of decreasing Saratva (responsible for Prerana) of the Shukra Dhatu and enhancing Shhiratva (which favors dhara), 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 Mansabhavas (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|
| Shradha  | 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 Mansabhavas (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 | <0.001|
| Veeryam  | 0.6 | 60 | 0.50 | 0.12 | 5.33 | <0.001|
| Avasthanam | 0.50 | 40 | 0.55 | 0.13 | 3.85 | <0.01|
| Shradha  | 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       |
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 sheegha 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 along 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.

### Table 9: Seminal parameters

| Seminal parameters | Studied sample | Normal values (WHO) |
|--------------------|---------------|---------------------|
| Liquefaction time (in minutes) | 22.4±12.63 | 20-30 |
| Viscosity (in cms) | 0.276±0.789 | |
| Volume (in cc.) | 2.74±1.268 | 1.5-5.0 |
| pH | 7.68±0.471 | 7.5-8.0 |
| Viability (%) | 68.7±15.96 | >60 |
| Sperm count (in millions) | 87.7±72.97 | >20 |
| Sperm motility (%) | 6.65±12.57 | >25 |
| RLP | 6.6±12.57 | >25 |
| SLP | 44.3±12.64 | >50 |
| Non-progressive | 11.8±8.727 | |
| Immotile | 38.4±114 | |
| Total abnormal forms (%) | 81.5±9.45 | <70 |
| Auto agglutination (%) | 7.14±15.35 | <20 |

WHO: World health organization

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Kulkarni and Chandola: Efficacy of Stambhanakaraka Yoga and counseling in premature ejaculation

हिंदी सारांश
शुक्रगत वात की चिकित्सा में स्तंभनकारक योग का चिकित्सिय अध्ययन

प्रसाद वी. कुलकर्णी, हरिमोहन चन्द्रोला

पुरुषों में शीघ्र रंगल एक बहुत ही ज्यलंत समस्या है। चित्ता, भय, शोक आदि शीघ्र रंगल के मुख्य कारण हैं। आयुर्वेद की दृष्टि से इस अवस्था को शुक्रगत वात के रूप में समझा जा सकता है। शीघ्र रंगल से प्रस्तुत ५० रूपयूं को २ वर्षों में विभाजित किया गया एवं चिकित्सार्थ १) स्तंभनकारक योग (n=३०) और २) प्लॉसियो चिकित्सा २ माह तक कोष्ठ जल अनुपात के साथ दी गई। दोनों वर्गों में सामान्य रूप से मानसिक अनुप्रदेश दिया गया। चिकित्सा के बाद स्तंभनकारक योग वर्ग में, प्लॉसियो की तुलना में सभी मापदंडों पर प्रभाव। IELT, शीघ्ररंगल पर ऐच्छिक नियंत्रण, रूपण और सहायता की तुल्य, चित्ता आदि में सार्थिक दृष्टि से महत्त्वपूर्ण लाभ हुआ।

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