Effect of Sensate Focus Therapy in the Management of Erectile Dysfunction Among a Group of Nigerian Men

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Abstract:
Erectile dysfunction which is commonly known as male impotence is a sexual dysfunction characterized by the inability to develop or maintain an erection of the penis sufficient for satisfactory sexual performance regardless of the capacity of ejaculation. This study investigated the relative efficacy of sensate focus therapy in the management of erectile dysfunction among a group of Nigerian men. In the Nigeria cultural setting, many men who suffer from erectile dysfunction feel too ashamed or inadequate to disclose it and are often afraid of being discovered. Hence, seldom does one find a Nigerian male who would discuss or admit openly to the presence of erectile dysfunction in his life. The researcher therefore chose sensate focus technique to find out its effectiveness in the management of sexual dysfunction. This work is an experimental study, which adopted a 3 x 2 factorial design. The sample was made up of 30 men who were randomly selected from the target population of 120 clients who were diagnosed impotent in Michael Okpara University of Agriculture Umudike Clinic. Three (3) instruments were developed and used in this study. The data obtained were analyzed using percentages, t-test and analysis of variance (ANOVA) at 0.05 level of significance. Results indicated that sensate focus therapy was effective in the management of erectile dysfunction among men. Based on these findings, the study therefore concluded that experts should be consulted in the management of erectile dysfunction as well as counselling instead of relying on orthodox medicine alone. Media publicity on health education should be a thing of priority, while issues that initiate anxiety in the home should be avoided as much as possible, as this does not go well with men’s sexual functioning.

Key Words: Sensate focus therapy, Management, Erectile dysfunction, Nigerian men

Introduction
Sex, is a natural function like digestion and, can be upset by a whole variety of problems, usually not involving physical factors. Similarly, if sex is allowed to happen naturally and in a relaxed way, our bodies will respond normally, without any conscious effort on our part. Common examples of problems or situations that can upset this normal sexual responsiveness are as follows: Misunderstanding among couples; Lack of information about sex (Fisher and Rosen, 2004). Bad feelings about sex or its consequences like: fear of pregnancy, or pain; fear of being caught, over heard or interrupted; fear of losing control, fear of your partner losing control; guilt and disgust (Madersbacher, 2005). Other factors such as anger, resentment towards partner, lack of self worth, depression, effects of alcohol and drugs interfere with normal responsiveness temporarily.

Erectile dysfunction is more commonly known as male impotence. Erectile dysfunction is a sexual dysfunction, characterized by the inability to develop or maintain an erection of the penis sufficient for satisfactory sexual performance, regardless of the capacity of ejaculation (Bacon et al., 2003). Erectile dysfunction is indicated when an erection is consistently difficult or impossible to produce despite arousal. There are various and often multiple underlying causes, some of which are treatable medical conditions. The most important organic causes are cardiovascular disease and diabetes, neurological problems, hormonal insufficiencies and drug side effects (Kostis et al., 2005).
Psychological impotence is where erection or penetration fails due to thoughts or feelings, rather than physical impossibilities, this can often be helped. Notably, in psychological impotence, there is a strong response to placebo treatment. In reality, it has been estimated, that around 1 in 10 men will experience recurring impotence problems at some point in their lives (De Rogatis and Burnett, 2007). With the introduction of Sildenafil citrate (Viagra) and other drugs in recent years, discussion of the psychological aspects and treatment of Erectile dysfunction may seem passé to some, even in the psychological communities (Berman and Berman, 2000). Blonna and Levitan, (2005) maintained that these factors combine to cause a patient trouble may not always be quite so straight forward. Getting and maintaining an erection is a complex process involving a number of cognitive, affective, behavioural and physiological factors. Physiological and psychological factors may separately or jointly contribute to the etiology and maintenance of erectile dysfunction. Typically, erectile dysfunction patients have a demonstrated problem with arousal regulation (Benet and Melman, 2000). Additional understanding of the functional and dysfunctional arousal process would further validate a useful psychological model of erectile dysfunction and help develop clinical applications for treatment of this disorder.

Because of the importance attached to sex and the pressure put on the male to perform, many young men suffer from erectile dysfunction of some sort. Many of such dysfunctions are of psychological origin. In the Nigerian society, sexual dysfunction in women might abound to the same or even greater extent than that in men, but since there is no physiological manifestation in the women, like the bulge in men’s trousers that would denote a functioning organ, then many women may go through life without bothering to rectify their dysfunction. Also a woman does not need to rectify many of these psychological or physiological sexual dysfunctions she might suffer from in order to conceive and bear a child. Whereas a man has to have an erection before intercourse can even take place not to talk of impregnating a woman. Hence, erectile dysfunction is of greater importance in the life of any Nigerian man who suffers from it.

In the Nigerian cultural milieu, many men who suffer from this dysfunction feel too ashamed or inadequate to disclose it and are often afraid of being discovered. Hence seldom does one find a Nigerian male who would discuss or admit openly to the presence of this problem in his life. The researcher, during her course of interaction asked the participants, what they would do if they ever become impotent (surprisingly many said they would commit suicide). Many more described erection as their reason for being alive or the symbol of their manhood. From this small sample, it was obvious, that having an erection symbolized the fulcrum of their existence, without which they regarded themselves a walking corpse. This attitude to sex, is learned early by a Nigerian child from his peers and the society at large, attitude towards any type of sexual dysfunction is further reinforced by myths, fallacies and jokes passed around by word of mouth. Lack of knowledge of ‘good sex’ performance, anxiety, and other factors exacerbated erectile dysfunction, as men are usually too proud and easily embarrassed to admit to a lack of knowledge or the presence of the dysfunction. In addition to these, other causes like aggression control, and intimacy can and do interfere with trouble

Sensate focus dwells more on enhancing closeness and intimacy, among couples, which may lead to intimate disclosure and effective reaction.

**AIM**

To determine the relative effectiveness of sensate focus therapy, in the management of erectile dysfunction among a group of Nigerian men.

**RESEARCH METHODOLOGY**

**Research Design**

This study is an experimental study which adopted a 3 x 2 factorial design. The sensate focus as well as the control group is represented in rows while the clients with high and low levels of education are represented in columns.
Table 1: Experimental 3 x 2 Factorial Design

<table>
<thead>
<tr>
<th>Treatment programme</th>
<th>Levels of Education</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensate focus</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Key
Group 1: Group 1:1 – Sensate focus/high education group
Group 1:2 – Sensate focus/low education group
Group 2: Group 3:1 – Control/High education group
Group 3:2 – Control/Low education group

Table 2: Distribution of Subjects and Levels of Education

<table>
<thead>
<tr>
<th>Subject Treatment Group</th>
<th>Level of Education</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensate focus – Group 1</td>
<td></td>
<td>N = 3</td>
<td>N = 3 -6</td>
</tr>
<tr>
<td>Control</td>
<td>Group 2</td>
<td>N = 3</td>
<td>N = 3 -6</td>
</tr>
</tbody>
</table>

The entire period covered by this study was 6 weeks, with 12 sessions. During this period, 10 men were treated with sensate focus, but only 6 completed therapies that are 60% of those treated with this method; and 10 men were placed in the control group, but only 6 returned to complete the post treatment forms, thus making 60% of those who were initially in this group. Many of these men did not complete the six weeks therapy. Some even did not come back after the first visit to the clinic. Some broke therapy for a long time, and later returned after a prolonged period of up to three weeks. Although these people were treated by starting therapy all over again, they were eliminated from the experiment, as the break in therapy might be a source of contamination, which might affect the overall result of the therapy and the experiment. On the whole only 60% of those who started therapy finished.

Area of Study
Michael Okpara University of Agriculture (formerly Federal University of Agriculture, Umudike, Abia State, Nigeria was established as a specialized university by the Federal Government of Nigeria decree No 48 of 2nd November 1992. Formal activities began in May 1993; with the appointment of the first Vice – Chancellor and the first governing council on 27th May, 1993. The institution is located in the well known agricultural training and city of Umudike, about 10km from Umuahia, the capital of Abia State, along the Ikot – Ekpene road. Umudike is located geographically, on latitude 05°129° north, longitude on 07°33° East and on altitude of 122m above sea level. The major link road to the University is the Umuahia – Ikot Ekpene Federal road, a direct route to the capital cities of Abia, Akwa – Ibom and Cross River States. As one of the three universities established by the federal universities of agriculture decree of 48 of 2nd November, 1992.
Population of the Study
The estimated target population of 120 comprised all those clients, who have been given a thorough medical checkup, and were diagnosed to be impotent and were receiving treatment from Michael Okpara University of Agriculture Umudike Clinic, Abia State. These clients, whose ages ranged from 40-60 years are married men, and have acquired enough education to enable them express themselves freely on the subject matter. They were able to respond appropriately to the questionnaire and benefitted from the training programmes.

Sample and Sampling Techniques

Subject Sample
Thirty (30) male patients, from the Medical Centre of Michael Okpara University of Agriculture Umudike, were used in this study. These clients have been given a thorough medical checkup and were obtained from over one hundred patients diagnosed to be impotent. These patients were between the age range of 40-60 years and were made up of subjects of both Christians, Moslems and artiest. Educationally, they were all literate, their academic qualifications ranging from primary six to university degree holders. They all could read and write to a large extent. The size of the sample was to ensure effective control of the subjects during the training programme. The small size sample of ten in each group was to ensure effective person to person contact, between the researcher and the clients and amongst the clients themselves, thereby providing effective group interaction and cohesion. The clients were required to sign an improvement of erectile dysfunction contract form, to make sure they would complete the therapy and promise to abide by the instructions given by the therapist, for the entire period of the therapy. The clients were then assigned to the two treatment group sensate focus and systematic desensitization and the control group.

Instrumentation
Development and Validation of Instrument
Instrument used in this study are:-Penile erection profile (PEP), Sexual habit inventory (SBI), Erectile Dysfunction Assessment Inventory (EDAI).

Penile Erection Profile
This is a test developed by the researcher. This test consists of five diagrams of the penis, at different stages of arousal. Each stage has a number assigned to it. The highest mark of five goes to the diagram denoting an erect turgid penis and the lowest mark along the continuum has a score of one and this is for the diagram denoting a flaccid penis. This test is mainly pictorial and is supposed to establish the state of the client’s erection at every sexual opportunity during a single day. Sexual opportunity may indicate encounter with persons of the opposite sex, thought of sex, watching erotic films, listening to music or even taking part in the sexual act. Although erect penis is not a conclusive indicator of sexual functioning but it gives an indication of the client’s responsiveness to sexual stimuli during the time he is away from the therapist.
In this study, penile erection profile instrument helped the researcher to know the responsiveness of the clients to sexual stimuli during the time he is away from the therapist.

Sexual Habit Inventory
This is a test also developed by the researcher. This test like the first one had its face validity ascertained by two members of the department of Guidance and counseling and two doctors from the medical centre of Michael Okpara University clinic. This test consists of twenty (20) items which tried to establish the sexual habit of the clients and how these habits changed after two weeks of intensive therapy. The questions have four (4) standard answers: Always, Often, Sometimes and Never. Each of which has a mark assigned to it from four (4) at the highest and one (1) at the lowest end of the continuum. Split half reliability to measure internal consistency was established at 0.65.

Erectile Dysfunction Assessment Inventory
This is another test developed by the researcher. This test consists of 12 items concerning the patients’ reactions to sexual situations. The response is based on a five point Likert type scale ranging from 5 to 1. Each point denotes a degree of arousal, whose interpretation is given by the key below:

**Keys:**

5  Fully aroused, erection is firm, long lasting as far as intromission or vaginal entry and till the end of ejaculation.
4  Fully aroused, erection is firm, lasting just until intromission or point of vaginal entry only.
3  Partially aroused, erection is slight and lasts, just until intromission or point of vaginal entry only.
2  Partially aroused, erection is minimal and last just before intromission or point of vaginal entry.
1  Not aroused and have no erection.

This instrument consists of the following questions:

**Validation of Instrument**

The instrument developed was given to the researcher’s supervisor and two experts from the Faculty of Education. These were one from measurement and evaluation and the other from curriculum studies. Corrections and suggestions made by these experts helped the researcher to modify the instrument, detect ambiguities and irrelevant items. Their comments and views were of immense help in writing the final instruments.

**Reliability**

The test retest method was used to determine the reliability of the instrument. Test retest reliability was obtained by administering the instruments to 10 subjects, drawn from the target population within Michael Okpara University of Agriculture Umudike Medical Centre. These men were used, because they attend the same clinic and work in the same environment, but not part of the groups that were used for the study. The data collected from the two tests, were analyzed using Pearson product moment correlation co-efficient and the result obtained was 0.84 which is reliable for the study.

**Techniques of Data Collection**

This study, adopted a three phase techniques for data collection comprising; pretreatment, treatment and post treatment phases.

1) The case history of the clients was obtained from the relevant hospital departments with the permission of the Chief Medical Director of the clinic. Each patient was then asked to come back for treatment at a given date.

2) After these questionnaires requesting for demographic details, target symptoms; presenting problems, family history, childhood adolescent and premarital sexual development and marital history were given to the client.

3) Each client underwent a thorough medical checkup, and had a medical report filled, in a medical questionnaire by the medical personnel of this department. This was to eliminate any physiological aetiology of the erectile disorder.

4) Clients were assigned into groups, by the group they picked and each client then met with the therapist.

5) Ground rules and general approach for the conduct of the therapy session were established.

6) Therapeutic contract, which was an agreement between the therapist and the clients for the client to take responsibility for his sexual development, to attend the treatment sessions regularly and promptly for the two weeks duration of the short term therapy session, and to complete exercises and assignments given by the therapist, was signed. This agreement was signed by the therapist, and the client was given a date and time in which to attend the next treatment session. This was done by all clients. The only difference between the control and the other two groups was that the control got no treatment at all in the two weeks between the pre and post treatment.

7) Treatment was given according to the treatment format enclosed for each group.
8) Sign or set of instructions of assignments to be performed by each client, was given to him at the end of each treatment.

9) At the end of the two weeks, all the test instruments were administered again to all clients. This was the post-test assessment.

10) Termination of treatment followed and the clients were given a date for a follow up in 1 months’ time to check the efficacy of the treatment methods.

Pre-treatment Phase
The pre-treatment phase was carried out to collect scores used as baseline data for the treatment programme. The researcher personally administered the instrument to each client by collecting their demographic data and after a thorough medical physical examination. Clients were asked to go home, with the completed penile erection form. This is to enable them mark the predominant state of their sexual responsiveness the day before at every sexual opportunity. This form should be returned each day for 14 days, after which the two other forms were filled.

Detailed Description of Treatment Programmes

Sensate Focus – Treatment Model in Group I
Sexual functioning is conceived as a natural physiological process, yet it is a unique facility, that no other physiological process, such as respiratory, bladder or bowel function can initiate. Sexual responsibility can be delayed indefinitely or functionally denied, for a lifetime. No other basic physiological process can claim such malleability of physical expression. Everyone takes advantage of this characteristic every day, as he rejects or defers untimely or inappropriate sexual stimuli, in order to comply with the social requirements of the moment.

The ultimate level in marital – unit communication is sexual intercourse. When there is complaint of sexual dysfunction, the primary source of absolute communication is interfered with or even destroyed and most other sources or means of interpersonal communication rapidly tend to diminish in effectiveness. Usually, the failure of communication in the bedroom extends rapidly to every other phase of marriage. Hence, the recommendation of sensate focus as a treatment module to bring the clients in tune with his body and that of his partner. Communication and attitudes are important between partners. Using this method, target behaviours are clearly defined at each stage. A behaviour contract is written. The main purpose of sensate focusing is to arrange task for the clients which would reduce anxiety and reward sexual behaviour by producing pleasure and ultimately leading to eradication of impotence and the beginning of a new sex life. Clients are encouraged to discover sensations of touch, smell, body contact and seeing each other naked, listening for sights, and signs of pleasure like laughter or deep breathing. Clients are encouraged to discover their partner’s erogenous zones.

The therapist describe and lay emphasis on the role that sensory appreciation plays in sexual response as a medium of social exchange vested primarily on touch. This premise of sensate value is based upon a cultural tendency. Communication is intended to give comfort or solace, convey reassurance, show devotion and describe love or physical need. All these are expressed first by touch. Olfactory, visual or auditory communication generally serves as a reinforcement of the experience. Sexual function is not just a physical expression, it is touch, smell, sound and sight, reflecting how men or women as sexual beings show what they feel and think, that bring responsive meaning to the sexual act. These factors are as important to the male as to the female. Touch is the primary medium of exchange.

Although, it is a natural physiological function, sexual responsively can be sublimated, delimited, displaced or distorted by inhibition of its natural components and/or alteration of the environment in which they are operant. As examples:

1) If sexual function is honoured as a natural process, but sublimated deliberately for sufficient valued reasons, a high degree of tolerance to sexual tension may exist, with grace and without distortion.

2) If sexual function is rejected or denied on honourable, or even acceptable role psychologically, yet actively sustained physical in spite of the rejecting value system, the result may be acquired sexual dysfunction.
3) If sexual function is undiscovered or unrealized because a natural, sequential development has been put without sustaining expectations, the result may be primary sexual fulfillment and/or psychosexual confusion.

Steps in the Use of Sensate Focus

This consists of two methods known as sensate focus I and sensate focus II.

Step I

Sensate focus I is the first stage in this therapy, and it involves taking history of client, educating clients concerning the sexual act, and teaching the clients sensory appreciation. All the assignments are carried out at home. The partner would have been appraised of the situation and the role she is to play in helping the male come to terms with his sexuality. The male and his partner should disrobe completely in the privacy of their room, as clothing can be distracting in the face of either partner’s awkwardness or embarrassment. One of the partners should approach the other first, and start to introduce manual touch to the partner. The partner doing the touching is the giver and the one receiving is the receiver or getter.

The getter should aid the giver by giving specific directions, as to the areas of the body where touch is desired and the type of touch desired i.e. firm, soft, hard and feathery. The giving partner is to trace, massage or fondle the getting partner with the intention of stimulating and giving the partner’s level of sensate focus. At first gentle trial and error approach should be taken, thus not alarming the dysfunction partner.

At this time, and until otherwise directed, neither partner is to approach or touch the genital areas of the other. There should be no specific sexual stimulation, physical or otherwise until the therapist suggests it. This process should be repeated with both partners swopping roles. The recipient has only the responsibility to protect the ‘pleasing’ partner from committing an error, which discomforts, distracts or irritates. There is no requirement to comment upon that which is pleasurable by word or even by body language unless the verbal or nonverbal communication is completely spontaneous. For most women and for many men, the sensate focus sessions represent the first opportunity they have ever had to think and feel sensuously and at leisure without intrusion (own or partner’s), without the need to explain their sensate preferences, without the demand for personal reassurance and without a sense of need to wish to ‘return the favour’. The partner who is pleasuring is committed first to do just that: give pleasure.

At a second level in the experiment, the giver is to explore his or her own component of personal pleasure in doing the touching, to experience and appreciate the sensuous dimensions of hard and soft, smooth and rough, warm and cool, qualities of texture, and finally, the somewhat indescribable aura of physical receptivity expressed by the partner being pleased. After each session a final reminder is given that the genital area and the woman’s breast should not be touched.

Body lotion could be used for massage of the non-genital and non-breast areas. Emphasis should be on caring, pleasure, relaxation, communication and feedback. Relaxation and touching form the fundamental foundation for all stages of this treatment; the body lotions were found to serve as a permissible medium of physical exchange, wherein the act of applying the lotion will provide the necessary ‘permission to touch, to give or receive tactile pleasure’.

The body lotion, can also serve as lubricant, which takes away the distraction of feeling rough and dry hand on the body. At each session discussion on feelings and achievement should be carried out. Instructions given by the therapists for the next session must reflect corrections of mistakes made during the last sessions and further instructions like inclusion of the signal systems should be included. This entails the ‘getter’ placing his/her hand on those of the giver to signal whether pressure is adequate or should be increased/decreased, as is required by the ‘getter’.

Step II

The second stage of this is Sensate Focus II, usually referred to as genital sensate focusing. This entails touching of the genital areas including the breast of the woman. The touch directed to the genital areas and breasts is to be offered and received without introduction of goal oriented, demanding stimulative effort, intended to produce pleasure. With sensate pleasure to the whole body without the pressures of sexual performance disturbing either
partner’s enjoyment of self-discovery, both partners should learn what turns on each other. At this time the therapist should make sure that the pelvic anatomy of both the female and male sex is familiar to the client.

As each new dimension of touch and feeling is appreciated, during the sensate focus period of concentration, these new sensual pleasures must be included to a greater or lesser degree in future occasions of sexual interaction. Sensual pleasure should be inherent in all sexual activity. It should not be hurried or timed. Clients should be told to continue their pleasuring to the extent of pleasure but should not continue if fatigued physically or emotionally. Intercourse should also be avoided at this stage. Clients should be asked to avoid striving for orgasm. This will come when they are ready.

Usually, within a week after the start of session, the client should have experienced partial or complete erection. Also, a teasing technique in which they stop touching each other and then start again, repeating this several times is encouraged. This takes the pressure off maintaining an erection if it was present.

When couples are found to be sufficiently confident and relaxed, with pleasuring each other, the day after full erection is developed they are encouraged to make love. Firstly, the woman must take responsibility for the first lovemaking session. She must be in the female superior position, sitting astride her partner, who lies flat on his back. Intromission should be attempted in a non-demanding manner. There should be no hurry to mount, or rush to obtain sexual tension release. When mounting, the female partner should be encouraged to move back on the shaft of the penis rather than to sit down on it. The woman always should control the insertive process. Many men have been distracted from a partial or even a full erection by bumbling, fumbling, vain attempts to penetrate the vaginal orifice in the process of penis insertion.

The underlying concept in the use of this mounting technique is to remove inherent male distraction and to let the sensual pleasure developed form mutual sexual stimulation take control, so that the tense male will not react in his usual pattern of performance fears or spectator role.

This experience should be repeated several times, until erectile security develops. The coital teasing technique is comparable to that of attaining, losing and then returning to full penile erection with manual manipulation. Any male must have a sensate of obviously successful intromissions, if he is ever to have permanently his concerns for performance. Impotent men, having achieved intromission successfully still have no: satisfied their performance fears. They immediately question, whether the penis will retain sufficient turgidity for continuation of effective coital connection.

These specific fears are easily obviated by once again contraindicating performance. It is authoritatively suggested first, that the female move slowly up and down on the shaft of the penis, which she can do with facility in the described positioning. She is to move backward and forward rather than sit down on the penis. The female partner should not be demanding. The therapist must explain before exposure to any coital opportunity that a demanding pattern of female pelvic thrusting is threatening to any man with erectile insecurity.Demanding female participating is immediately distracting to the impotent male, for his performance fears come flooding back. Once conscious of loss of any degree of the erection, the impotent man panics, forgetting immediately, that by his own actions as a phantom spectator, he distracts himself from sensate input. When he succumbs to this response pattern, the penis becomes flaccid in seconds to the utter frustration of both sexual partners.

Both partners must learn that there is no time demand inherent in this female mounting technique. If the erection satisfactory, intromission proceeds if not, play is continued without pressure, until a satisfactory erection does develop. If erection does not develop during a comfortable period of time with mutual play, there is never to be an attempt to force the issue.

After the female has taken her turn at the sensate pleasure of feeling and thinking sexually, while moving pelvically in a slow, non-demanding manner on the penile shaft, it is suggested, that she in turn remain quiet and the man is encouraged to thrust slowly, concentrating on the sensate pleasures to be obtained from the feelings of vaginal contraction and warmth of containment, and the sensations engendered by the female’s lubrication. The male should think of giving and receiving pleasure just as though he was stroking the female’s back, nibbling her neck etc – that way, he is distracted from concerns of performance, and the biophysical and psychosocial stimulative input of sensate pleasure is encouraged.
After this, on subsequent days both partners are encouraged to move to simultaneous pelvic pleasuring, feeling, thinking and concentrating only on the sensations involved in this mutually of their sexual stimulation. The male must not concern himself with satisfying the female or forcing ejaculation. Satisfaction and ejaculation should be involuntary natural and mutually rewarding, but never by direction. A state that is physiologically inhibitory to anxiety, usually relaxation, is induced, and then the patient is exposed to a weak anxiety arousing stimulus. Progressively stronger stimuli are introduced as the weaker ones are tolerated, until the strongest stimulus is reacted to with the degree of anxiety, that the mildest stimulus evoked, which is then reduced to zero.

Sensate Focus Treatment Plan

<table>
<thead>
<tr>
<th>Day</th>
<th>Activities For The Day (Therapist Activities)</th>
<th>Duration</th>
<th>Client activities</th>
</tr>
</thead>
</table>
| 1.  | a) Welcoming clients  
     b) Filling of demographic questionnaire | 60 mins  | The clients introduced themselves and became friendly with the therapist and group members. |
| 2.  | Assigning them to Doctors in the consulting rooms who will give a thorough physical check-up to ascertain initial diagnosis of erectile dysfunction or impotence | 60 mins  | The clients waited patiently and cooperated with the doctor during their physical examinations. |
| 3.  | a) Assigning clients to the three groups, by picking numbers from a box.  
     b) Making appointment with each member of each group in order to fix the time and date for the next treatment session. | 45 mins  | Clients picked number as they come. They participated in taking decision on the days and time for therapy sessions. |
| 4.  | a) Filling in of pretest forms.  
     b) Signing of contract forms with clients.  
     c) Giving instructions on sensate focus: This is a period or responsibility for one partner’s pleasure (giving to get) | 90 mins  | The clients listened attentively and internalized the explanations. |
| 5.  | a) Description of the male sex organs.  
     b) Description of role of sensory appreciation in sexual response. | 90 mins  | Clients listened and asked questions where necessary. |
| 6.  | a) Clients were taught on how to discover partner’s body without touching the pelvic or breast areas or attempting intercourse.  
     b) Couples were encouraged to draw pleasurable sensations from various forms of stimulation. | 90 mins  | Clients contributed to the discussion and listed out some factors that hindered them from frequent touching. |
| 7.  | a) Home assignments were reviewed on massage while nude  
     b) Partners communicated likes and dislikes, yet the goal is still not to become aroused. | 60 mins  | The clients paid attention to the therapist and asked questions where applicable. |
| 8.  | a) The therapist explained that mistakes must be made in order to learn, so the partner mustn’t feel shy to make mistakes.  
     b) The therapist encouraged clients to ask questions in order to clarify matters.  
     c) At this stage clients were advised to include touching of the breast and genital organs with more verbal communication. | 60 mins  | Clients promised to carry out the home assignment as instructed by the therapist. |
| 11. | a) Give to get was emphasized  
     b) Teasing encouraged. The day after full erection occurs and is maintained client was allowed to try intercourse with his wife. | 60 mins  | Clients solicited for the therapist advice to their wives for effective cooperation and tolerance. |
| 12. | a) Client were advised to return in month’s time for follow up.  
     b) The therapist emphasized on the need for client to practice and maintain all that they have been taught throughout this period of therapy. | 90 mins  | Clients appreciated the therapist effort towards their wellness and promised to live up to expectations. Promised to keep the |
Post Treatment Phase
At this point, therapy was terminated. Post test forms were filled. Appointments were given for follow up and check up in a month’s time. Having recorded meaningful improvements, clients were happy to terminate the therapy and expressed their gratitude to the therapist who had through her knowledge given them a new sense of belongings. They promised to keep the one month appointment with the therapist.

Follow-up Phase
In order to ascertain the level of improvement recorded, after the treatment programme, one month appointment was given to the client to see the therapist.

Method of Data Analysis
The data collected was analyzed, using frequency distribution, mean, and percentage to response to the research questions, while t-test, ANOVA (Analysis of Variance) were used, to test the hypotheses at 0.05 level of significant. ANOVA was used, because of its advantage in increasing precision in randomized experiments. Analysis of variance, test the significant differences, between means of the final experimental data. It takes into account the correlation, between the dependent variables and one or more covariates, therefore corrects the initial mean differences in the pre-test measures, between the experimental groups. It also takes the correlation, between the pre-test and post-test measures into account. Thus analysis of variance reduces the effect of extraneous variations in pre-test measures on post-test measures.

Control of Extraneous Variables
This study is an experimental study. It has some inherent problems attached to it. In order to ascertain, that the observed changes in sexual behaviour of the clients were due to the effectiveness of the training programmes and not to some extraneous variables, the researcher attempted to control the variables in the following ways:

1) Clients were randomly selected and assigned to the experimental and control groups, thus ensuring equivalence in groups.
2) The researcher interviewing and conducting therapy by herself alone, thus limiting sources of contamination.
3) Giving standard explanation to couples and how to carry out their home assignment
4) Stating the hypothesis as a null hypothesis, rather than directional so as to overcome researcher bias or Rosenthal effect.
5) Making sure those questionnaires was not long so that patients don’t become fatigued.
6) The researcher filed in the questionnaire herself for clients that are not well educated to avoid wrong answers.

RESULTS

Table 4.1: Mean Rating Analysis of Management of Sexual Dysfunctional Men Using Sensate Focus Therapy.

<table>
<thead>
<tr>
<th>S/N</th>
<th>Item Specification</th>
<th>∑X</th>
<th>X</th>
<th>STD</th>
<th>Remarks</th>
<th>Pooled Mean</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>I have intercourse with my regular girl friend/wife.</td>
<td>19</td>
<td>3.10</td>
<td>1.01</td>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I have intercourse with others or have extramarital sex.</td>
<td>10</td>
<td>1.60</td>
<td>0.93</td>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I undergo manual stimulation of my sex organ (masturbation)</td>
<td>15</td>
<td>2.46</td>
<td>0.81</td>
<td>Sometimes</td>
<td></td>
</tr>
</tbody>
</table>
I think of sex and have oral genital contact 15 2.50 0.92 Often
I fantasize about sex whilst having sex or doing something. 16 2.67 0.96 Often
I like watching erotic films which culminate in giving me an erection. 17 2.7 0.94 Often
I have wet dreams or nocturnal emissions 16 2.67 0.94 Often
I have spontaneous erection on seeing a woman naked 16 2.67 0.94 Often
I get an erection when my partner and I play with each other. 17 33 1.04 Often
I experience full arousal till the end of ejaculation 17 2.83 1.02 Often

Source: field data, 2014.

The result of Table 4 showed, summary analysis of data, with respect to management of sexual dysfunctional men using sensate focus. The analysis reviews, that apart from items 2 and 3, whose means are respectively 1.60 and 2.46, which are below the criteria means of 2.50, the other items 1, 4, 5, 6, 7, 8, 9, and 10 have means ranging from 2.50 to 3.80, which are greater than the criteria mean.

Table 5: Summary of t-test Analysis of Sensate Focus Therapy and Control Group

<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>Std error</th>
<th>t_cal</th>
<th>t_tab</th>
<th>df</th>
<th>Sign Level</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A Sensate focus</td>
<td>6</td>
<td>2.62</td>
<td>0.40</td>
<td>0.202</td>
<td>3.27</td>
<td>1.81</td>
<td>10</td>
<td>0.05</td>
<td>Reject H0</td>
</tr>
<tr>
<td>Group B Control</td>
<td>6</td>
<td>1.96</td>
<td>0.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Field Data, 2014.

Table 5 shows, the result of data analysis with respect to erectile dysfunctioning of clients, exposed to sensate focus therapy and those in the control group. The result shows a calculated value of t to be 3.27, which exceeds (is greater than the tabulated value of t = 1.81, at 0.05 level of significant and 10 degrees of freedom. Therefore, the null hypothesis of no significant difference was rejected. Hence, there is a significant difference between the erectile functioning of clients exposed to sensate focus therapy and the control group.

Discussion
This research work found out that with sensate focus therapy many men can now have intercourse with their regular partner, practice stimulation of the sex organ, fantasize about sex, while having it or thinking about it and mere oral genital contact can cause erectile functioning. Many men have wet dreams or nocturnal emissions and spontaneous erection on seeing a woman naked. The confession of improvement, showed that the treatment have been so effective, that when they simply play with their partners, they experience erection and do have full arousal till the end of ejaculation. These findings agreed with Van Hasselt and Michael (2006), who posited, that one of the most useful couple oriented activities for enhancing mutual sexual enjoyment is a series of touching exercise, called sensate focus. According to them, with increasing awareness and attention paid to this holistic sense aspects of sex, potency often reforms. However, Fraser and Solvey (2004) gave a new dimension of sensate focus therapy and posited that it provides opportunity to bring about second order “change”. The therapy, with their emphasis on experiencing pleasuring thought of the body, from head to toe, will enable many couples acquire a new set, that significantly expanded their capacity to experience erotic pleasure.

Althof (2000) asserts that impotence is not a naturally occurring phenomenon. According to him, some men are more susceptible to combinations of etiological factors which can push them so far from their natural cycle of sexual response, that they develop fears of effective functioning. These fears, Althof (2000), observed can distract or obviate the possibility of full erectile response to any form of sexual stimulation. This study found out, that many Nigerians are engulfed, with these problems of anxiety which culminated to sexual dysfunction and the sensate focus therapy has succeeded in removing the fears reorient the conditions of involuntary behavioural pattern, so the
client becomes an active participant for his sexual performance. (Althof, 2000), has the same view as expressed by De Villers (2004) who pointed out, that many sexual dysfunctions of longstanding can be taken care of by mainly understanding and common sense approach for their resolution. McCabe (2001) has given a more directly relevant view acquired of how sexual behaviours may be acquired, through general social, psychological learning principles and various behavioural methods utilized to unseat this anxiety. Sensate focus dwells more no enhancing closeness and intimacy among couples which leads to effective reaction, relaxation and confidence. The use of these psychological techniques rather than medical approach to improve erectile function has been effective in the management of sexual problems in many parts of the world.

Conclusions
Management of sexual dysfunction men using sensate focus exercise was effective in the reduction of anxiety and enhancing mutual sexual enjoyment. Couples increased awareness and attention paid to this aspect of sex, potency was reported restored and more sensation was felt in the sex organs. There was a significant difference in the erectile functioning of clients, exposed to sensate focus exercise and the control group. Couples should be encouraged, to learn the primary goals in treating impotency, through removing of the husband’s fear of sexual performance, by re-orientating his involuntary behavioral patterning, so that he becomes an active participant. Wife should be of help to the husband’s erectile dysfunction treatment through effective participation. Government through the Ministry of Health, should encourage doctors and other health workers organize seminars and workshops to enlighten the public on how to identify erectile dysfunction, especially in men and treatment there in. many will be identified and families will be re-invigorated and many sexual dysfunctions of longstanding solved. Every general hospitals, tertiary hospitals and health centres should have trained counselors who can offer Guidance education on sexual dysfunction and psychological remedies for sexuality information. The introduction of sex education into the school curriculum, should incorporate topics like; behavior counseling, learning theory treatment, aversion therapy, or any other behavior change that may be necessary. Schools should employ counselors who should handle these topics and offer other counseling services to the students and teachers. Marriage courses organized by churches should include these therapeutic methods of treating erectile dysfunction, through psychotherapy and how the knowledge could save marriages. Qualified counselors should be invited to enlighten the couples on this natural physiological process. Information about human sexuality, erectile dysfunction and methods of treatments should be made available through the media, pamphlet published by government and distributed to people, seminars held in churches and public places. This will remove the superstitious believe of causes of erectile dysfunction in men. Finally, issues that initiate anxiety in the home should be avoided as much as possible, as this does not go well with men’s sexual functioning.

References


