CHAPTER I
INTRODUCTION

I INTRODUCTION

Human fertility control has been a burning problem in mankind from time immemorial and continues to be one of the important issues even today. It is four decades since the oral contraceptives, antiseptic plastics and stainless steel Intra Uterine Devices (IUD) were introduced marking the beginning of the contraceptive revolution. Never before have men and women had such control over fertility. In spite of the wide availability of this sophisticated contraceptive technology, unplanned pregnancy continues to be a burning problem. There has been dramatic shifts in the use of different methods of birth control, with a side by side influx of new methods daily in the market.

Each method introduced in the market has been analysed and tested for its efficacy, safety and suitability for the users. In this process of evaluation, no method has so far been judged as 'the perfect' method for the users. Rather, it has been a well accepted fact among users that "Birth control methods are not free of side effects". The invention of a new method, time and again, confirms this fact.

One should realize that use of birth control methods is influenced by many factors which have been identified as determinants and consequences of birth control behaviour. This birth control behaviour has been identified as a complex behaviour that is influenced by a number of antecedent and intervening variables of which psychological perspective
constitute an important dimension. The study of the psychological perspective of human fertility control is popularly referred to as "Fertility regulating behaviour" by psychologists, stressing the link between behaviour of some sort which is defined on one side and feelings and attitudes on the other.

Psychologists working in this field have identified a number of determinants influencing fertility control. KAP studies, for instance, demonstrate that socio-demographic factors like education, religion, parity, age and interval since last birth contribute to acceptance of birth control. Some other studies have highlighted the role of psychological factors like modern attitudes, value orientations, subjective efficacy, openness to change, husband and wife communication etc., as being directly or indirectly related to acceptance or resistance of birth control. Another set of studies have focused their attention on the impact of birth control methods in terms of psychological health problems arising out of its use. A lot of studies have been done in terms of psychological sequelae following the use of various methods. The popularity of 'abortion' and sterilization had led to studies of the above nature.

One area that has not been touched by many researchers in spite of its important contribution to the acceptance or resistance of birth control is "sex". Often its importance goes unnoticed; yet the influence exerted by this lone factor is so dramatic that one cannot afford to ignore its contribution in making the birth control a success or failure. The relationship between sex and birth control may not be direct. But it goes without saying that the potential outcome of heterosexual
activity includes the possibility of conception (whether desired or not) and birth control is a behaviour that intrudes upon the normal outcome of the heterosexual activity. The psychological impact of this intrusion on the normal consequence of this biological activity is complex. This complexity arises because "sex" in human beings is not a mere instinct directed towards satisfaction, but also a mode that helps in creating the nucleus of society i.e., the 'family'. Therefore when this normal outcome of heterosexual relations has to be regulated due to economic and other reasons, the consequences of the intrusion are many. It would be interesting to understand how birth control affects 'sex life' from the following two angles:

1. Are these birth control methods by themselves causing any problem to sexual adjustment?
2. What are the psychological influences of these methods on one's sex life?

This type of an understanding is very important and worthwhile if we have to get a feedback of why a method has failed or has been accepted. In short,

Thus we see that the problems and complications associated with
birth control are varied and many and a study of them can provide useful information to policy makers in making future decisions.

II. HISTORICAL ACCOUNT

a. A Brief Sketch of Population Studies: Studies on 'population' and its related factors began as early as 1662 when John Graunt, an Englishman, initiated empirical research on population studies. During the 18th and the 19th centuries, research in population increased in the West; but due to high mortality rate, interest shifted to this area, with research on population becoming sporadic.

After the second World War, the developing countries directed their attention on 'fertility control' as the population growth was increasing, due to control of epidemics, invention of medicines etc.

b. Population Studies in India: India has a long history of population studies. From Kautilya (323 B.C.) to Akbar (1502 - 1605) a lot of work had been done. However only after the second World War, India took the problem seriously. India was the first country in the world to launch a nation-wide Birth control programme with full government support. It accorded very high priority for the programme from the First Five year Plan (1952) and the importance continues even today.

A comparative analysis of the programmes in India and the West shows that the programmes have been far more successful in industrialized nations where changing attitudes to birth control has come from the masses of people, while in India, the scene is different in as much as the attitude change is promoted
from the socially and economically better off classes, which in turn has resulted in a low success rate.

c. Historical Aspects of Abortion: 'Abortion' is the oldest and most widely practised method of birth control. Abortion has been resorted to by different societies at different periods of history for a variety of reasons. In spite of its wide use, nearly all cultures and societies have tried to control and regulate it through social mores, moral conventions, religious taboos or government laws. The codes of some of the earliest civilizations that arose centuries before the Christian era dealt with the problem. The code of the Sumerians of 2000 B.C., the code of the Assyrians of 1500 B.C., the Hammurabic code of 1300 B.C., the Hindu code of 1200 B.C. and the Persian code of 1000 B.C. had all dealt with the problem of Abortion.

The Old Testament (circa 600 B.C.) refers briefly to accidental miscarriage, but does not specifically touch 'induced abortion'. Possibly it was not a serious problem among the Jews then. Most of the Greek philosophers, Plato (427 - 348 B.C.) and Aristotle (384 - 322 B.C.) in particular, approved of 'Abortion' and encouraged it.

d. Status and Popular Trends in Contraceptive Use over the Years:

With the identification of the 'population explosion' as a threat to the human kind, methods to control the outburst have been developed and still continue to be developed all over the world. A wide choice of methods is available to users; yet, when one goes through the history of the use of birth control methods, one notes that the popularity of these methods differed from time to time.
A study conducted by Harvey S. Marie (1974) on the trends in contraceptive use among the American women from 1974-1983 showed that the pill was the most popular contraceptive, followed by Intra Uterine Device (IUD) and Diaphragm. A survey conducted in 1987 by the International Health Foundation, as a part of a multi-country study of the use of contraceptives revealed that use of contraceptives is extremely high among Swedish women and they prefer reversible methods like pills or IUDs. Very few choose sterilization. The pill is most popular among the young and the IUD among the old. A survey on French women carried out by the Institut National d'Etudes Demographiques in 1988 found that in France, the use of the pills and the IUDs has increased substantially and the use of 'withdrawal' as a method has been falling. It revealed that 72% of the French women use contraceptives of which 64% use reversible methods.

ii. Trends in the Use of Contraceptives in India: From 1950’s when India started Family Planning programmes, there has been a definite trend in the use of contraceptives. In the 60’s, the pill and the IUD were most popular. Then came the era of Sterilization in the 70’s, as the people were concerned about the side effects of the Pills and the IUDs. However, in the mid-70’s Sterilization became unpopular due to overindulgence in compulsory sterilization. With the legalization of Abortion in the 70’s, it was used as a method to get rid of unwanted pregnancies. In the early 80’s, the IUDs had again become popular and in the late 80’s, both the IUDs and the Sterilization have been popular.
The trends in the use of contraceptives in the U.S.A. have been more liberal in its views on 'sex' and related matters. Hence, the Americans, unlike the Indians, are well aware of the various methods of birth control and invariably use some method or the other. The trend in the choice of the methods also differs from India. Pills and Diaphragm lead the list. Abortion, though not legal, is popular among all age groups. However, permanent methods have not been popular.

The historical account of sexuality shows that sex and sexual behaviour have been debated upon time and again. Sexual activity has been vilified and praised, proscribed and encouraged, damned as sinful and glorified as holy. In a few societies, invariably short-lived ones, sex had even been banned. But in all cultures in record, sex has been regulated. Over the centuries, these regulations have swung back and forth in severity between the license of ancient Rome and the prudence of the Victorian England; but never have they altered so abruptly as in the 20th century. All over the world, traditional attitudes to 'sex' have been broadened or abandoned in a sexual revolution that is perhaps the most significant development in human behaviour today. Factors like the drive for equality of women, advancing technology and scientific study are responsible for this.

Attitudes towards sex have varied with time and place. For more than 2000 years, religion was the principal force that shaped these attitudes. In the last 150 years or so, with the advent of sexology as a science, there has been a radical change in these attitudes. However, the idea that 'sex' is a pleasure to be enjoyed by all is hardly a recent one. As early as in the year
2 B.C., the Roman poet Ovid published the 'Art of Love', a work with surprisingly modern ring. It was in the early Christian era that the joys of the body were condemned as sinful. One man most responsible for this change was the Carthaginian professor of rhetoric who became to be known as St. Augustine. His tirades against sex, along with those of the latter theologians influenced the lives of the people in the western world in every generation till the last century.

The works of Krafft Ebing (1846), Hawlock Ellis (1859 - 1939) and Freud (1856 - 1939) were the pioneers of modern thought on sexual attitudes. Kinsey (1894 -1956) and Masters and Johnson (1954) carried the thoughts further.

However in recent years, it is scientific research that is moulding modern attitudes to sex. Many investigations have used direct observations to gain further information on sexual physiology. Some studies have focussed their attention on particular components of sexual response such as brain wave change during orgasm (Cohen, Rosen and Goldstein 1976), changes in blood pressure and breathing patterns during intercourse (Fox and Fox 1969 and Nemec, Mansfield and Kennedy 1976).

Research on sexual dysfunction has also attracted increasing attention in recent years. Studies on homosexuality, sexual dysfunction have spurted and sex clinics have mushroomed. Thus the post Kinsey era has been one of rapid expansion of sexual knowledge and corresponding changes in sexual attitudes and behaviour.
III DEFINITION OF CONCEPTS

a. Family Planning Programmes: Family Planning programmes are interventions that try to influence people's decision to limit family size either directly through provision of methods or indirectly through developmental efforts like maternal and child health centres and improving women's status.

The World Health Organization defines Family Planning Programmes as a systematic way of controlling the family size to the desired number, for the desired period of time through provision of methods, educating and raising the level of awareness to problems of population control and providing better health and living conditions.

b. Birth Control: Birth control techniques or fertility control methods are methods used by a couple during the fertile period of their life span to regulate their family size to the desired size and number for the period of time they consider necessary. The various methods for limiting the family may be referred to as Family Planning methods, Fertility Control methods and Birth Control methods. These methods may be classified as follows:

1. Natural Methods - this includes such age-old practices as 'coitus interruptus', 'safe period', 'rhythm method' and 'temperature control.'

2. Birth control Methods for men - these are the Condoms and the Vasectomy.

3. Birth control Methods for women - these include the Pills, the Intra Uterine Device (IUD), the Diaphragm, the Abortion, and Sterilization (or 'Laparoscopy').
Abortion: This term both in legal and obstetric practice is generally applied to the premature expulsion of the product of conception i.e. before 24 weeks of pregnancy. But the word 'abortion' being old and vague has acquired in popular parlance a pejorative connotation. According to the dictionary, to abort is 'to bring forth premature offspring'. In the clinical sense, 'abortion' refers to the physiological process of evacuating a pregnant uterus; but in the legal sense, it refers to 'Induced Abortion'. Abortion is still a topic which arouses deep feelings based on attitudes to a tabooed area.

Before having recourse to an abortionist, many women with unwanted pregnancies attempt to end them by utilizing a series of time honoured measures of dubious efficacy like skipping, jumping, hot-bath and drugs. Peter Turnpenny (1960) has classified the drugs used for illegal abortions as i) purgatives, ii) substances causing uterine contractions, iii) herbal oil producing pelvic congestions, iv) local applications on vagina such as mercury salts and v) specific drugs such as folic acid which deprive the fetus of essential vitamins.

Anthony Horden (1977) says these substances have to be taken in near-fatal doses and in producing abortion they may severely poison or even kill the pregnant woman. If these methods failed, a desperate person would attempt interference with knitting needles etc., which are pushed into the vagina or cervix with dangerous results. If all these measures failed, then she would try to have her pregnancy terminated through "Illegal medical operation" or a legal medical operation.
Fig A: Insertion of Lamanaria prior to dilatation and curettage.

Fig B: The swollen Lamanaria & dialate & softened cervix about 18 hrs later.
The method of terminating a pregnancy is commonly decided by the duration of pregnancy. The various techniques for performing "Abortion" currently in use are:

I. SURGICAL
   a. Cervical dilation and mechanical evacuation
      i. Curettage
      ii. Vacuum aspiration (Suction curettage)
   b. Laparotomy
      i. Hysterotomy

II. MEDICAL
   a. Oxytocin intravenously
   b. Intra-amniotic hyperosmotic fluids
      i. 20% of saline
      ii. 30% urea
      iii. 50% dextrose
   c. Prostaglandin E2, F2a and derivatives
      i. Intra-amniotic injection
      ii. Extravular injection
      iii. Vaginal insertions
      iv. Parenteral injection
      v. Oral ingestion
   d. Various combinations of the above

I SURGICAL

A. DILATION AND EVACUATION: Surgical abortion through vagina is performed by first dilating the cervix and then evacuating the products of conception mechanically by curettage, or by the technique of vacuum aspiration (suction curettage) or both. Mechanical dilation of the cervix at the time of abortion is a
potentially traumatic procedure. The risk of trauma can be minimised by inserting an agent into the cervical canal that will slowly dilate the cervix. Laminaria tents are used in Japan and the U.S.A. to help dilate the cervix for "Abortion". The tents are made of seaweed obtained from northern ocean waters. The stems are cut, peeled, shaped, dried, sterilized and packed in different sizes. At the time of abortion the luminary is removed by grasping the attached thread and the vulva, the vagina and the cervix are cleaned.

B. HYSTERECTOMY: In a very few circumstances abdominal hysterectomy is preferable to either dilation and curettage or medical induction. The techniques employed are similar to cesarean section except that the incisions are made smaller.

II MEDICAL

a. DYSTOCIN: Once the cervix has undergone sufficient dilation, intravenously administered oxytocin is very effective in evacuating the contents of the uterus.

b. INTRA-AMNIOTIC HYPERSONOMATIC SOLUTIONS; In order to effect abortion during second trimester of pregnancy, 50% dextrose, 25% saline or 40% urea are injected into the amniotic sac to stimulate uterine contractions and cervical dilations.

c. PROSTAGLANDIN: Prostaglandin E2, P2s are administered orally, parenterally into the amniotic sac extravascularly and as a vaginal suppository placed adjacent to the cervix.

STERILIZATION: Sterilization is the final and most irrevocable method of contraception. The first surgical sterilization was carried out in 1987 in the United States. In women, the common method of sterilization comprise tubal ligation, tubal excision,
laproscopic sterilization. For couples whose families are complete and who wish to rid themselves of concern about contraceptives, sterilization is often the best solution. Tubal ligation involves an internal surgical operation; the abdomen is opened under anaesthesia and a section of the fallopian tubes is cut and removed so that the ova cannot pass through. Therefore this operation is best done after the birth of a baby, when the tubes are in a relatively accessible position.

THE IUD:— The Intra Uterine Device or the IUD as it is commonly known is a plastic or metal object that is placed inside an uterus and left there as long as contraception is desired. It comes in a variety of shapes each having its own advantages and disadvantages. The most commonly used IUDs include the L-shaped ring, double coil, spiral, bow, steel ring and the copper T. Exactly how these devices work is uncertain, but one possibility is that they prevent or disrupt the implantation of the embryo after conception. Another possibility is that they interfere with fertilization by stimulating the ovum to travel very rapidly through the fallopian tubes.

THE PILLS:— The modern steroid oral contraceptive generally known as 'the pill' is composed of the female hormone estrogen and of progestin, a synthetic substance that is chemically similar to the natural progesterone produced by a women's ovaries. This combination suppresses ovulation. The pill is taken daily for 20 or 21 days of the 28 day cycle, beginning on the fifth day after the onset of the menstrual period. The steroids may be administered sequentially or in a combined form. In the sequential system, the estrogen is administered alone during the early part of the cycle, with the progestin added only during the
latter part. The pills have the effect of regularizing the menstrual cycle to exactly 28 days, even in women who never had regular cycles before. Moreover, the menstrual flow is noticeably reduced.

**CONDOMS**: is a thin rubber or latex sheath used to cover the penis, during intercourse. The condoms are found in different varieties.

**DIAPHRAGM**: is a latex sheath that is to be inserted inside the vagina with a gel so as to hold it in place, such that it lies at the opening of the uterus.

**VASECTOMY**: is the surgical operation done on males in order to prevent pregnancy. The operation involves identification of the vas deferens, (the tube that carries the semen from the testicles to the urethra) and cutting & tying of the tubes such that the passage of the semen is hindered.

c. **Sexual Adjustment**: Sexuality is a multi-dimensional phenomenon, having biological, psychological, behavioural, clinical and cultural aspects. Freud (1943) saw sex as a powerful psychological and biological force, while Malinowski (1929) emphasizes its social and cultural dimension. In everyday life sex is often used to mean physical activity involving the genitals (having 'sexual relations'). In addition to its reproductive value, sex can be a means of communicating, expressing and building self-esteem. In order to understand the concept of sexual adjustment, it is essential to understand the anatomy, physiology, the sexual response cycle, and sexual dysfunctions.
1. SEXUAL ANATOMY: This concerns the organs of reproduction and parts of the body that are potential sources of sexual pleasure.

a) THE FEMALE SEXUAL ORGANS:

i) The vulva: This is the external sex organ (meaning covering) and consists of the mons, the labia, the clitoris, and the perineum.

ii) The mons: This is the area over the pubic bone which consists of a cushion of fatty tissue covered by skin and pubic hair. Since this organ has numerous nerve endings, touch or pressure on this may lead to sexual arousal.

iii) The labia: The outer lips (labia majora) of the vulva are folds of skin covering a large amount of fat tissue and a thin layer of smooth muscle. The labia are important source of sexual sensation for most women, since they are made up of many nerve endings.

iv) The Clitoris: One of the most sensitive areas of the female genitals is situated beneath the point where the top of the inner lip meets. The only visible portion of the clitoris is the clitoral head that appears like a button. The clitoris is richly endowed with nerve endings which makes it highly sensitive to touch. It is unique because it is the only organ in either sex whose primary area is to accumulate sexual sensations and erotic pleasure (Master and Johnson 1970).

v) The Perineum: It is the hairless area of skin between the bottom of the labia and the anus.

vi) The Hymen: The vaginal opening is covered by a thin tissue membrane called the hymen.

vii) The Vagina: This is the muscular internal organ that tilts upwards at a 45 degree angle diagonally pointed towards the small
FEMALE SEXUAL ANATOMY

1. Mons Venirus
2. Clitoral Hood
3. Clitoral Shaft
4. Urinary Opening
5. Labia Majora
6. Labia Minora
7. Vaginal Opening
8. Hymen
9. Perinum
10. Anus
of the back. In the unstimulated state, the vagina's walls are collapsed.

MALE SEXUAL ORGAN:

i) The Penis: It is an external organ that primarily consists of three parallel cylinders of spongy tissue bound in thick membrane sheaths. The cylindrical body on the underside of the penis is called the spongy body. The urethra, the tube that carries urine or semen, runs through the middle of the spongy body and exits at the tip of the penis via the urinary opening. The skin that covers the penis is freely movable and forms the foreskin.

ii) The Scrotum: This is a thin loose sac of skin under the penis that is sparsely covered with hair and contains the testis. The scrotum has a layer of muscle fibre that contracts due to sexual stimulation.

iii) The Testis: These are paired structures contained in the scrotum. It has two functions of producing hormones and sperms.

d. Sexual Philosophy: Human sexual response is multidimensional, with inputs from feelings and thoughts, learning and language, personal and cultural values and many other sources combining with our biological reflexes to create a total experience. To understand this complex behaviour it is necessary to become familiar with the philosophy of sex, i.e., the functions of human sexual anatomy. There are two mechanisms that explain how various organs respond to sexual stimulation. They are the vasocongestion and the myotonia. The vasocongestion is the enlargement of blood vessels and increased influx of blood into
1. GLANS
2. URINARY OPENING
3. URETHRA
4. TESTIS
5. SCROTUM
the tissues. Ordinarily the inflow of blood into organs will be balanced by the outflow of blood into the veins. But under certain circumstances, the inflow of blood will exceed the outflow. This condition leads to vasocostriction. During sexual stimulation there occurs a vasocostriction in the body tissues of the genitals and the breasts. The myctonia is the increased neuro-muscular tension. This response involves activation of the parasympathetic system and inhibition of sympathetic fibres resulting in vasocostriction and sexual activity.

e. the Sexual Response Cycle: Masters and Johnson's (1966) study indicates that the human sexual response cycle has four stages. They are the excitement, the plateau, the orgasm, and the resolution. These stages correspond to various levels of sexual arousal and describe the typical responses of people during sexual function.

i. Excitement: This results from sexual stimulation. In the female the first sign of excitement is the appearance of vaginal lubrication. Beads of secretion appear as droplets and eventually moistens the entire inner walls of the vagina thus facilitating the smooth insertion of the penis. Other changes like the expansion of vagina, uterus and cervix being pulled up and the flattening and the moving apart of the outer lips of the vagina also take place at his time. In the male, the erection of the penis is the most predominant sign of arousal.

ii. Plateau In this stage the high levels of sexual arousal are maintained and intensified. In the female prominent, vasocostriction causes the outer third of the tissues to swell.
Excitement Stage

Male

1. Partial Elevation of Testis
2. Unstimulated State
3. Partially Stimulated State
4. Full Erection

Female

1. Uterus
2. Bladder
3. Clitoris
4. Labia Swell
5. Vaginal Lubrication
1. Cowper's Gland
   Secretion
2. Color Deepens
3. Prostate Enlarges
4. Cowper's Gland
5. Testes Fully Elevates
6. Increase in Size of Testes
7. Scrotum Thickens

1. Uterus Enlarges
2. Vagina Expands
3. Orgasmic Platform
4. Color Change Labia
The inner lips of the vagina enlarge dramatically as a result of increased blood supply. They then push the outer lips apart, providing greater access to the vaginal opening. In the male the diameter of the head of the penis increases slightly, this area often deepens in colour due to a gush of blood. As sexual tension mounts towards orgasm, the test is not only continues to elevate but also begin to rotate forward. Small amount of clear fluid appear in this stage.

**Orgasm:** If effective sexual stimulation continues late in the plateau phase, a point may come when the body suddenly discharges its accumulated sexual tension in a peak of sexual arousal called the orgasm. Biologically the orgasm is the shortest phase of the sexual response cycle during which rhythmic muscular contractions produce intense physical sensations followed by rapid relaxation. Psychologically, orgasm is usually a time of pleasure and suspended thought when the mind turns inward to enjoy the personal experience.

Orgasm in females is marked by simultaneous rhythmic muscular contractions of the uterus and the outer third of the vagina. Women often describe the sensation of orgasm as beginning with a momentary sense of suspension, quickly followed by an intensely pleasurable feeling that begins at the clitoris and extends through the body.

Orgasm in men occur in two stages. In the first stage, the tubes that carry sperm begin a series of contractions that forces semen into the bulb of the urethra. In the second stage the contractions of the urethra and penis combine with contractions of the prostrate glands leading to ejaculation. The
1. **Penile contractions**
2. **Urethral contractions**
3. **Prostate gland contracts**
4. **Rectal sphincter contracts**
5. **Seminal vesicles contract**

1. **Rhythmic contractions in orgasmic platform**
subjective experience of orgasm in men starts. Consistent with the sensation of a deep warmth, orgasm is then felt as sharp, intensely pleasurable contractions.

iv. Resolution: During this stage all the sex organs return to their normal states of rest.

f. Sexual Dysfunction: The psychosexual dysfunctions are characterized by disturbances in the sexual response cycle i.e. the process through which human beings progress from sexual desire to arousal, orgasm and finally relaxation. Inhibitions along this chain of any response is a dysfunction. This results in distress manifested by reduced sexual pleasure and a reduced sexual performance.

Theoretical Perspective on the Etiology of Sexual Dysfunction:

Freud (1905 - 1962) wrote that the 'sexual instinct' or 'libido' is determined by many factors and it is not static; but it is subject to modification and even suppression. Freud conceptualized dysfunction as a consequence of distortion of the sexual instinct caused by inhibition and repression during sexual maturation.

Kinsey (1945) believed that individuals are born with an innate capacity to respond to physical or psychological stimuli and that most aspects of human sexual behaviour is learnt; it is a product of conditioning as well. The attitude that an individual develops as a result of this learning and conditioning would have considerable significance in determining
Resolution Stage

Male

1. Erection disappears
2. Scrotum thins
3. Testis descends

Female

2. Uterus lowers
3. Vagina returns to normal
the subject's acceptance or avoidance of particular type of sexual activity.

Masters and Johnson (1900) felt that sexual function is a natural process that can be inhibited or denied expression due to prior negative conditioning experience.

Kaplan (1974) believes that human beings have a sexual urge that can be suppressed or diverted; a person can survive indefinitely without it. This dichotomy between urgent craving and the ability to delay, sets the groundwork for sexual dysfunction.

The psychiatric sexual dysfunctions are classified by DSM III classification as follows:

<table>
<thead>
<tr>
<th>DSM III diagnosis</th>
<th>Predominant Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhibited sexual desire</td>
<td>Lack of desire for sexual activity</td>
</tr>
<tr>
<td>Inhibited sexual excitement</td>
<td>Failure to attain or maintain erection in male or failure to obtain lubrication in female</td>
</tr>
<tr>
<td>Inhibited female orgasm</td>
<td>Delay or absence of orgasm</td>
</tr>
<tr>
<td>Inhibited male orgasm</td>
<td>Delay or absence of ejaculation</td>
</tr>
<tr>
<td>Premature ejaculation</td>
<td>Early ejaculation due to lack of control</td>
</tr>
<tr>
<td>Functional dyspareunia</td>
<td>Painful intercourse</td>
</tr>
<tr>
<td>Functional vaginismus</td>
<td>Involuntary vaginal muscle spasm</td>
</tr>
</tbody>
</table>

There are three major influences on sexual problems. They are constitutional, psychological and organic. Constitutional factors are the biological determinants of behaviour such as libido and ease of arousal. Psychological factors include all the emotions, cognition, interactional and cultural factors that are known to determine and influence
behaviour. Organic factors include the many recognized physical factors such as disease process, medication etc. that structurally or chemically interfere with sexual function.

9. Attitudes:

The concept of attitude helps us to explain the consistency of a person's behaviour (Allport), since a single attitude may underlie many different actions. It includes the idea of unconscious determinants of behaviour and the dynamic interplay of conflicting motives which call for adjustment.

Gordon Allport (1935) stresses the central importance of attitudes and says "this useful, one might almost say peaceful, concept has been so widely adopted that it has virtually established itself as the keystone of the edifice of American social psychology". Originally, the term referred to a person's bodily position or posture. In social science, however, the term has come to mean 'a posture of the mind' than the body. While defining the term, many different aspects of the concept of attitude have been stressed by many authors. Lundberg (1929) defines attitudes as the general set of the organism towards an object or situation which calls for adjustment. Warren (1934) defines attitude as a condition of readiness to act. Allport (1935) provides a comprehensive definition. He says attitude is a mental or neural state of readiness organized through experience exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related. Thus attitudes are unobservable intervening variables which influence the relationship between stimulus, events and behavioural responses (McGuire 1969).
Functions of attitudes: Katy (1979) says that there are four major functions of attitudes. They are:-

1. Understanding - attitudes help us to understand our world and to make sense of occurrences around us.

2. Need-satisfaction - many attitudes are helpful in satisfying our needs and reaching our goals. They help us to adjust to life situations.

3. Ego defence - attitude can also help us to enhance our self-esteem and to defend us against the 'hardships' of life.

4. Value expression - A value expressive attitude is helpful to establish a person's self identity.

All of us have a thousand of attitudes towards different objects; not all are active at the same time. Most of our attitudes are dormant; a few only direct our behaviour and call for attention. It requires the onset of a particular psychological need or a relevant environmental cue for an attitude to be aroused into an active state. The chances of what condition will arouse what need depends on the function that the attitude will serve.

Dimensions of Attitude: There are two important dimensions, the valence and the complexity, of attitudes. The valence of an attitude is the degree of favourability or unfavourability of the person's feelings towards an object. Complexity of attitude means the number of elements that an attitude contain. Basically attitudes have three components viz. a) cognitive, b) affective and c) behavioural. (Krech, Crutchfield and Ballackey, 1962). Fishbein and Ajzen (1972) believe that the three aspects are not
the components of attitude, but they are three different concepts that are interrelated to attitudes as well.

HEALTH PROBLEMS: One of the major reasons cited for the low rate of acceptance of birth control methods are the physical and psychological problems often associated with them by the user. By health problems both the physical and psychological problems that arise out of the use of a birth control method are taken into consideration. Under the physical problems, problems such as weight gain, weight loss, nausea, tiredness, excessive bleeding, and the like are considered. So far as the psychological problems are concerned, problems such as depression, guilt, anxiety, etc. are considered. These factors have been selected for study under the topic of health problems on the basis of the findings of an earlier study conducted by the present investigator. [Sundari K.P. 1989].

IV PSYCHOLOGICAL FACTORS IN BIRTH CONTROL

In the long history of birth control, people have realized that a multitude of factors contribute to the success or otherwise of birth control. This is seen from the changes in approach that the programmes have undergone over the decades. Psychological and social factors as important determinants of birth control have been well recognized.

Social factors such as religion, social status, urban/rural background, etc., have been found to exert important influence on the acceptance or rejection of a birth control method. The effects of psychological factors on the
success or failure of a birth control method are pervasive. As a method is used by a person, personal variables like motivation, adjustment, personality and attitude of a person towards a method used all are bound to have a bearing on the success of a method. While quite a few studies have concentrated on the effects of psychological variables like personality, learning, adjustment, perception in general, very few studies have been conducted on the effects of these factors on the use of birth control methods.

A very important psychological factor that is bound to have profound influence on the use or otherwise of a birth control method is 'SEX'. The age old traditional and religious beliefs consider sex as 'a means for procreation only'. Modern views on the function of sexuality do recognize the undeniable aspect of the function of sexuality as 'the mode of procreation'. Since the use of a birth control method is contrary to the primary or a very important goal of 'procreation', it would be highly interesting to make an in depth study of how 'sex', the important aspect of human behaviour, is affected by the act of using a birth control method.

Although in the 1950's one or two studies did mention about the impact of 'abortion' on 'sex life', no detailed study in this area has so far been done. With an influx of knowledge on 'sex and sexual behaviour' in the seventies due to a revolution in the attitude towards 'sex', it will be worthwhile to understand the impact of the birth control methods on the most important aspect of human behaviour, the 'sex'.

Therefore the present study focuses its attention on
the impact of the birth control methods on sexual adjustment and the attitudes towards sex, along with an assessment of the psychological and social impact of the methods in a cross cultural sample.